

Training Material for Maternal and Child Health including Family Planning

A selected annotated
bibliography for teachers
of primary health workers

Hermione Lovel

Published on behalf of



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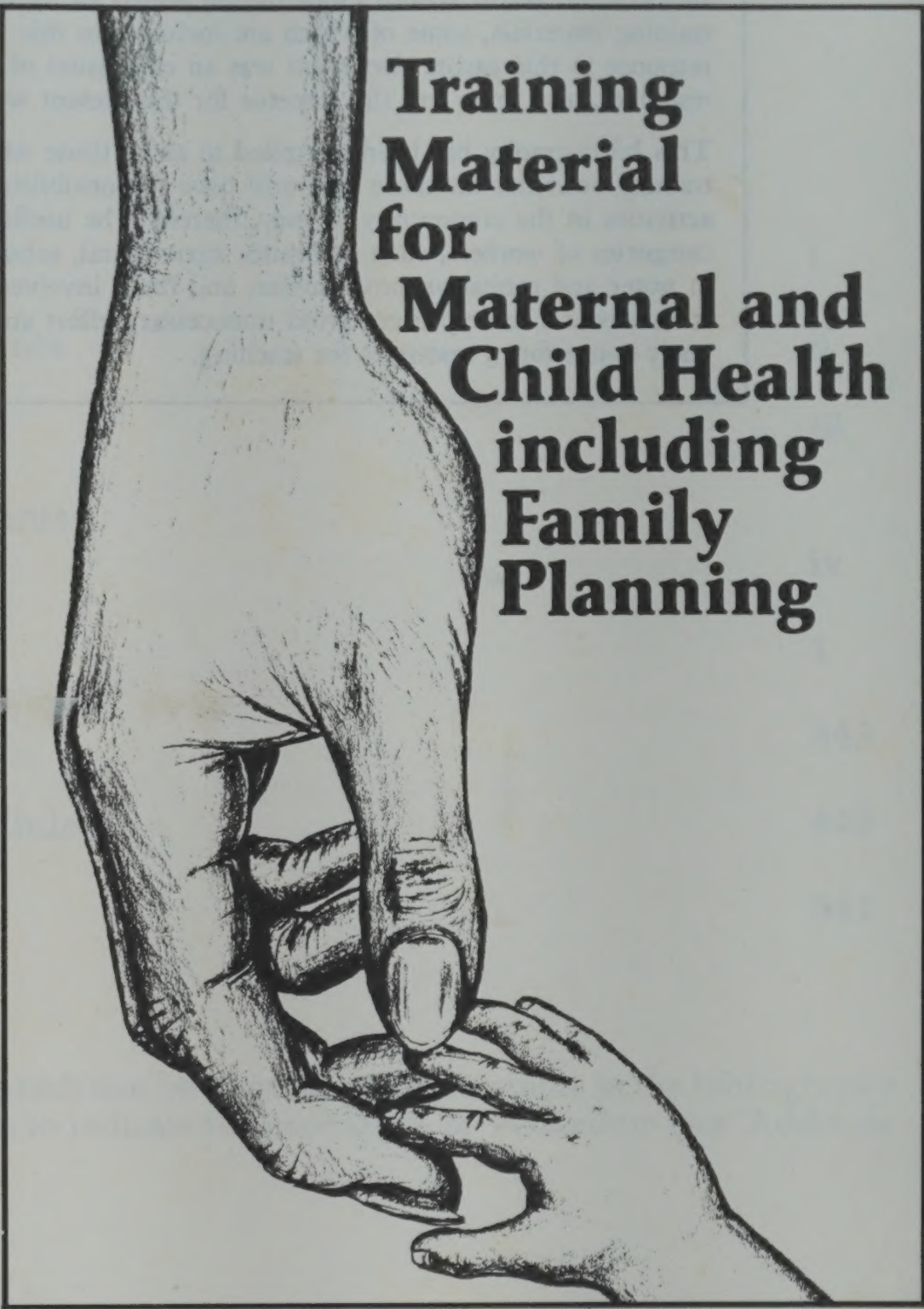
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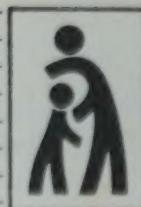
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Training Material for Maternal and Child Health including Family Planning



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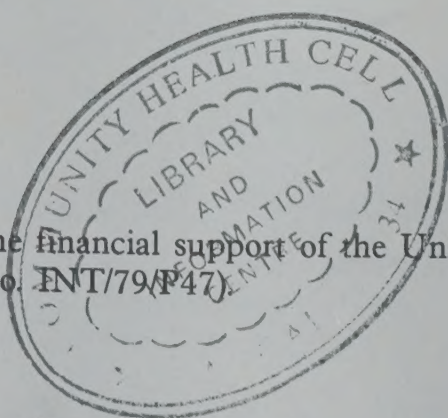
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In 1979 the World Health Organization issued an unpublished bibliography of training materials, some of which are included in this volume. The enthusiastic response to this earlier document was an expression of the need for additional resources, and thus, was the impetus for the present work.

This bibliography has been compiled to assist those who are engaged in developing training activities for those who will have responsibility for health or health-related activities in the community. It may, therefore, be useful for trainers of many categories of workers, such as health, agricultural, school teachers, peripheral workers in water and sanitation programmes, and those involved in community development. It endeavours to help users avoid unnecessary effort and expense by providing, in a ready-to-use form, resources for teaching.

This publication was made possible by the financial support of the United Nations Fund for Population Activities (Project No. ENT/79/P47).



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► This symbol, which can be found at relevant points in the bibliography sections 1-11, is to indicate the position of an addendum (see 'Addenda' on page 443).

Preface

In 1979 the World Health Organization issued an unpublished bibliography of training materials, some of which are included in this volume. The enthusiastic response to this earlier document was an expression of the need for additional resources, and thus, was the impetus for the present work.

This bibliography has been compiled to assist those who are engaged in developing training activities for those who will have responsibility for health or health-related activities in the community. It may, therefore, be useful for trainers of many categories of workers, such as health, agricultural, primary school teachers, peripheral workers in water and sanitation programmes, and those involved in community development. It endeavours to help users avoid unnecessary effort and expense by providing, in a ready-to-use form, resources for teaching. The annotations in the bibliography express the views of the author and do not necessarily reflect the policy of WHO in all areas. It is hoped that readers who are aware of materials that have not been included in this volume will bring them to the attention of WHO by writing to: Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

Acknowledgements

A number of people have significantly contributed to the development and publication of this bibliography.

In the World Health Organization: Karin Edstrom, formerly Medical Officer in the Maternal and Child Health Unit and presently WHO/UNICEF Senior Medical Liaison Officer, initiated the document which preceded this bibliography as well as the present work; Joan Bentley, formerly Public Health Nurse/Midwife in the Division of Family Health, continued to orient the book and to ensure that it remained practical for everyday use by busy people; and Donna Erstling, Technical Officer in the Division of Family Health, coordinated the preparation of the bibliography.

In the Institute of Child Health, London: Pat Harman, Public Health Nurse and David Morley, Professor of Tropical Child Health contributed materials for review; Gebreab Barnabas and Gill Tremlett, former MSc Fellows at the Institute of Child Health, helped to prepare some of the annotations.

In the British Life Assurance Trust the principal staff involved in producing the final version were Dr. Don Clarke, Director; Peter Bennallick, Graphic Designer; Bernadette Carney, Information Officer/Librarian, and Suzanne Silverman, Secretary.

The World Health Organization gratefully acknowledges the financial support of the United Nations Fund for Population Activities for the preparation and publication of this bibliography. (Project no. INT/79/P47)

Introduction

I Who is the bibliography for?

The bibliography is aimed at teachers who are training community health workers in the subjects of maternal and child health and in family planning services.

In particular, the emphasis of the bibliography is on helping those teachers engaged in training community health workers at the village level. Such workers are likely to include rural midwives, traditional birth attendants etc. and they will often be multi-purpose workers in the sense that they will tend to have more than one role or function in the village.

II How is the bibliography to be used?

Each of the first nine sections of the bibliography is subdivided into five key topics and under each topic there appears a list of annotated items. Most of the annotated items are complete in themselves, especially where the original source of information is difficult to obtain or out of print, and the most useful items are asterisked (*). The intention is to provide enough information about any topic to enable a teacher to construct a teaching programme. A procedure is given for making use of a cross referencing system or obtaining an item from its source if a teacher feels that more information is required than appears under the annotated item.

The last two sections, ten and eleven, describe how a teacher can implement - put into effect - the teaching programme that has been constructed from the annotated items.

Organisation of the bibliography

The bibliography is arranged in eleven parts; care of mothers in pregnancy and childbirth; child nutrition and promotion of food supply; promotion of normal growth and development of children and young people; promotion of mother and child health through birth spacing/family planning services; prevention of MCH disease through promotion of environmental sanitation and hygiene; care of the sick child; care of the injured child; help for the mother or child with a handicap or disability; planning, organisation and evaluation of MCH care; and learning how to teach others to provide better MCH care.

Example of how to use the bibliography.

1. Select the subject to be taught e.g. Section 2 Child Nutrition and Promotion of Food Supply.

2. Examine the five key topics in this subject.
 - (i) Finding out about child nutrition in the community
 - (ii) How can child nutrition problems be tackled
 - (iii) Evaluating nutrition teaching and nutrition intervention programmes
 - (iv) Useful sources of nutrition teaching material
 - (v) Newsletters to enable teachers to update their knowledge
3. If the information given under any topic item is insufficient, turn to the title and/or author index where references to other related information in the bibliography are given.
4. If it is desired to obtain the source from which the annotated item came then the following procedure applies.
 - (i) Check that the item is not out of print
 - (ii) Check that the item is easy to obtain
 - (iii) If the item is a WHO publication it can be obtained directly by writing to the World Health Organization, Distribution and Sales Service, 1211 Geneva 27, Switzerland, or through the following booksellers:

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- BELGIUM:** Office international de Librairie, 30 avenue Marnix, 1050 BRUSSELS — *Subscriptions to World Health only:* Jean de Lannoy, 202 avenue du Roi, 1060 BRUSSELS
- BRAZIL:** Biblioteca Regional de Medicina OMS/OPS, Unidade de Venda de Publicações, Caixa Postal 20.381, Vila Clementino, 04023 SÃO PAULO, S.P.
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III Background information

For the purpose of library searching and selection of relevant learning material, a simple framework was used for describing mother and child health services and the training procedures relevant for them. This framework was based on three sources: a matrix for task analysis for Maternal and Child Health (MCH) care produced by WHO (1) and an analysis from Ghana of the tasks to be performed in primary health care (2) and a recent task analysis by WHO of the eight essential elements of PHC (3).

- (1) World Health Organization (1978) "Matrix for task analysis for personnel outside hospitals for MCH care". (WHO Technical Document: MCH.FP/78.1)
- (2) Institute of Development Studies (1978) "Health needs and health services in rural Ghana". IDS, University of Sussex, Sussex, UK.
- (3) World Health Organization (1981) "Analysis of the content of the eight essential elements of primary health care." (HCP/PHC/REP/81.1)

Criteria for selection of the material

The main criterion used was that the material should be useful to senior teachers of health workers concerned to learn more about how to provide relevant MCH services and how to teach community health workers aspects of MCH care appropriate to their future working needs. References to the teaching-learning process; child care and nutrition; family planning; environmental health; community diagnosis, and coordination with other sectors, since these are the topics most likely to be new to many senior health workers, were considered to be particularly important.

The material was selected giving preference to references which are readily available at low cost; which have been produced in order to meet specific requirements in a programme; which appear to be readily adaptable; and which use simple illustrations. Preference was also given to material which includes either checklists, case studies or questions to enable users to become easily involved and interested in the material.

For some of the sections, very little or virtually no material was found. For a list of the most important omissions, see "Gaps" below.

Sources of information used in the compilation

Three main sources of information were used in the compilation. The World Health Organization (WHO) in Geneva, the International Planned Parenthood Federation (IPPF) in London and the Tropical Child Health Unit at the Institute of Child Health.

Other important sources of information were: the Institute of Development Studies (IDS), Sussex; Appropriate Health Resources and Technologies Action Group, Ltd. (AHRTAG), London; the International Extension College, Cambridge, the International Children's Centre, Paris and UNESCO, Paris.

Abbreviations

AHRTAG	Appropriate Health Resources and Technologies Action Group
FAO	Food and Agriculture Organization of the United States
IDS	Institute of Development Studies, University of Sussex
ILO	International Labour Organisation
IPPF	International Planned Parenthood Federation
MCH	Maternal and Child Health
REMAHA	Reference Material for Health Auxiliaries, WHO
TALC	Teaching Aids at Low Cost
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNICEF	United Nations Children's Fund
WHO	World Health Organization
*	Indicates particularly recommended material

IV The Future

Gaps in the material: Information request

All potential sources of training material could not be explored for this bibliography. Some of the identified gaps can probably be filled with existing material, either published or unpublished, that has been developed in the field. It is hoped that readers will share material that they have found useful by notifying WHO.

Three key procedures that are important tools in service planning are rarely covered in MCH material readily available for teaching or planning. These procedures are: development of job descriptions; setting of criteria for recruitment and selection; and supervision procedures that are supportive rather than merely checking procedures. Little simple and practical material exists on how to plan and manage supplies; costing; procurement procedures; scheduling maintenance of equipment, or evaluating how supplies are being used. Other problems that need to be better covered are e.g. how to organize transport effectively, how to arrange target schedules for maintenance of vehicles and how to assess what mileage per month would be expected.

Teaching staff also need help in planning and organizing their time so that their work in the community and their supervision is done efficiently. Guidelines are needed for supervision and in-service training by senior staff and for effective self-appraisal by all workers.

Information is needed on the methods for costing of training programmes, i.e. salaries, grants to students, buildings, materials, and transport. For maternal care, guidelines could be useful on how to set up a hospital hostel for antenatal women who are at "high risk" and waiting for delivery; and practical illustrated methods on how to transport pregnant women to hospital in an emergency when no motorized transport is available. For child care, guidelines are needed on the identification of "at risk" children at a clinic (e.g. those with low weight for height) and those "at risk" in the home. For environmental health, more diagrams are needed of low-cost procedures, e.g. for water protection, latrine building, refuse collection and waste water disposal.

Simple, low-cost reference material is needed for community workers with a low literacy level on nearly all maternal and child health topics; e.g. good teaching descriptions of "at risk" persons that can be identified during antenatal or child care sessions or home visits. Descriptions and examples of stories to be used for explaining MCH material in the vernacular would also be helpful. There is a growing awareness that many community workers need to be involved in community development, and, therefore, guidelines for how they might do this are also needed. Material is needed, both for teachers and (simplified) for community workers, on how to diagnose a community's health problems and how to assess a community's health care resources.

Practical guidelines for various types of health workers on how to work closely with workers from other sectors would be useful; for instance, on collaboration with school teachers for child care and health education, with agricultural teachers or advisers on nutrition and foods.

Outline of Contents of Sections 1-11

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1. Care of mothers in pregnancy and childbirth.	1	1
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8. Care of the injured child and prevention of further accidents especially at home.	309	8
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Detailed Contents of Sections 1-11

1. Care of mothers in pregnancy and childbirth.

- 1.1. Antenatal care
 - 1.1.1. Screening of risk cases and provision of appropriate care
 - 1.1.1.1. Recognising mothers at high risk of developing complications during pregnancy
 - 1.1.1.2. Providing special care for high risk women
 - 1.1.2. Antenatal tetanus immunisation
 - 1.1.3. Prevention and treatment of disease/complications during pregnancy
 - 1.1.3.1. Diseases arising or exacerbated by pregnancy (anaemia, malaria, pre-eclampsia)
 - 1.1.3.1.i. Anaemia in pregnancy
 - 1.1.3.1.ii. Malaria in pregnancy
 - 1.1.3.1.iii. Pre-eclampsia (toxaemia)
 - 1.1.3.2. Recognition and care of complications
 - 1.1.3.2.i. Overview of danger signs
 - 1.1.3.2.ii. Vaginal bleeding during pregnancy
 - 1.1.3.2.iii. Convulsions in pregnancy (and labour)
 - 1.1.3.2.iv. Genetic problems
 - 1.1.3.2.v. Twins
 - 1.1.3.3. Harmful effects of drugs in pregnancy
 - 1.1.4. Antenatal education for pregnant mothers (and fathers)
 - 1.1.4.1. The first nine months of life (conception and growth in utero)
 - 1.1.4.2. Harmful habits in pregnancy
 - 1.1.4.3. Keeping fit in pregnancy: avoiding back strain etc.
 - 1.1.4.4. Nutrition in pregnancy
 - 1.1.4.5. Danger signs in pregnancy
 - 1.1.4.6. Using maternity services
 - 1.1.4.7. Teaching pregnant mothers about labour and delivery
 - 1.1.4.8. Teaching pregnant mothers (and some fathers) about care of the newborn
 - 1.1.4.9. Teaching pregnant mothers about breastfeeding
 - 1.1.4.10. Teaching pregnant mothers about birth spacing
 - 1.1.4.11. Teaching pregnant mothers about child development
 - 1.1.5. Planning, organisation and evaluation of antenatal care
 - 1.1.5.1. Planning antenatal care
 - 1.1.5.2. Organisation of antenatal care
 - 1.1.5.3. Evaluation of antenatal care
- 1.2. Delivery care
 - 1.2.1. Ensuring aseptic delivery
 - 1.2.2. Monitoring labour with partograms and clocks

- 1.2.3. Determining presentation and position
- 1.2.4. Management of normal labour and delivery
 - 1.2.4.1. Signs of impending labour
 - 1.2.4.2. Management of the normal first stage of labour
 - 1.2.4.3. Management of the normal second stage of labour
 - 1.2.4.4. Management of the normal third stage of labour
 - 1.2.4.5. Care of the normal newborn baby immediately after delivery
 - 1.2.4.6. Care of the normal mother postpartum
- 1.2.5. Management of abnormal labour and delivery
 - 1.2.5.1. General sources on problems with delivery
 - 1.2.5.2. Problems in the first stage of labour: prolapsed cord
 - 1.2.5.3. Problems in the second stage of labour
 - 1.2.5.3.i. Breech delivery
 - 1.2.5.3.ii. Delivering the second twin
 - 1.2.5.3.iii. Faeces in the baby's nose and mouth
 - 1.2.5.3.iv. Cord wrapped around the baby's neck
 - 1.2.5.3.v. Need for symphysiotomy
 - 1.2.5.3.vi. Episiotomy
 - 1.2.5.3.vii. Tearing of the birth opening
 - 1.2.5.3.viii. Difficulties with delivery of the shoulders
 - 1.2.5.4. Complications of the third stage of labour
 - 1.2.5.4.i. Bleeding
 - 1.2.5.4.ii. Retained placenta (with little bleeding)
 - 1.2.5.5. Problems in the newborn baby
- 1.2.6. Planning, organisation and evaluation of delivery care
 - 1.2.6.1. Planning of delivery care
 - 1.2.6.2. Organisation of delivery care
 - 1.2.6.3. Evaluation of delivery care
- 1.3. Postnatal care
 - 1.3.1. Early recognition and treatment of complications after childbirth
 - 1.3.1.1. Postpartum complications in the mother
 - 1.3.1.2. Postpartum complications in the baby
 - 1.3.2. Postnatal advice to parents on newborn child care, nutrition, breastfeeding, family planning, etc.
 - 1.3.3. Planning, organisation and evaluation of postnatal services

2. Child nutrition and promotion of food supply.

- 2.1. Finding out about child nutrition in the community
 - 2.1.1. How do you find out if the children are growing properly?
 - 2.1.2. What are the food problems in your community?

- 2.1.3. Learning about some of the causes of malnutrition
- 2.1.3.1. How does infection affect malnutrition?
- 2.1.3.2. Socioeconomic factors and malnutrition
- 2.1.3.3. Low birth weight and the cycle of undernutrition
- 2.1.3.4. Closely spaced children and malnutrition
- 2.1.3.5. Seasonal factors and malnutrition
- 2.1.3.6. Breast milk substitutes and malnutrition
- 2.1.3.7. Goitre and cretinism
- 2.1.3.8. Lack of fibre and malnutrition
- 2.1.3.9. Child anaemia
- 2.1.3.10. Blinding malnutrition, Vitamin A deficiency
- 2.1.3.10.i. Measles and blinding malnutrition
- 2.1.3.10.ii. Newsletters
- 2.1.3.11. Unhealthy new habits and malnutrition

- 2.2. How can child nutrition problems be tackled?

- 2.2.1. Choosing which child nutrition problems to tackle

- 2.2.2. Treating infection, preventing disease and monitoring growth
- 2.2.2.1. Running an under fives clinic and treating infection
- 2.2.2.2. Running a community based weighing programme
- 2.2.2.3. Helping older children look after younger children better
- 2.2.2.4. Where diarrhoea is a problem, running an oral rehydration clinic
- 2.2.2.5. Running an immunisation programme

- 2.2.3. Promotion of food supply and income earning activities
- 2.2.3.1. Increasing crop production
- 2.2.3.2. Food storage to reduce post harvest loss
- 2.2.3.3. Improving the availability of fuel for cooking
- 2.2.3.4. Income generating activities

- 2.2.4. Special care for child nutrition at vulnerable times
- 2.2.4.1. Nutrition before pregnancy
- 2.2.4.2. Nutrition during pregnancy
- 2.2.4.3. Breastfeeding
- 2.2.4.4. Weaning
- 2.2.4.5. Care of the malnourished child
- 2.2.4.6. General design of nutrition education programmes

- 2.3. Evaluating nutrition teaching and nutrition intervention programmes

- 2.4. Useful sources of nutrition teaching material

- 2.5. Newsletters for teachers to keep up-to-date with nutrition and nutrition education

3. Promotion of normal growth and development of children and young people.

- 3.1. Overview
- 3.2. Promotion of physical growth and development
- 3.3. Promoting emotional development
- 3.4. Promoting language development and intelligence
- 3.5. Promoting social and psychosexual development

4. Promotion of mother and child health through birth spacing/family planning.

- 4.1. Introduction
- 4.2. The health benefits of birth spacing
 - 4.2.1. Healthy mothers
 - 4.2.2. Healthy children
 - 4.2.3. Happy families
- 4.3. Introducing birth spacing/family planning to the community
 - 4.3.1. Finding out about the community's needs for birth spacing/family planning
 - 4.3.1.1. Finding out about the local community
 - 4.3.1.2. Finding out the pattern of birth interval in the community
 - 4.3.1.3. The demand for family planning services shown by induced abortion
 - 4.3.1.4. Recognising people need healthy children to supplement the family income
 - 4.3.1.5. Evidence of unmet need for contraception and of population pressures nationally and locally
 - 4.3.2. Providing and evaluating birth spacing/family planning services
 - 4.3.2.1. Birth spacing by child weight not age
 - 4.3.2.2. District level services
 - 4.3.2.3. Health centre level services
 - 4.3.2.3.i. Task analysis and goal setting for health centres
 - 4.3.2.3.ii. Health worker roles and birth spacing training (general)
 - 4.3.2.3.iii. Clinics for birth spacing services
 - 4.3.2.4. Community based health and family planning overview
 - 4.3.2.5. Fieldworker activities
 - 4.3.2.5.i. Fieldworker and workplace planning and organisation

- 4.3.2.5.ii. Fieldworkers - evaluation of birth spacing
- 4.3.2.6. Village health worker activities
- 4.3.2.6.i. Village health worker planning and organisation
- 4.3.2.6.ii. Village health worker evaluation
- 4.3.2.7. TBA activities
- 4.3.2.7.i. TBA birth spacing planning and organisation
- 4.3.2.7.ii. TBA birth spacing evaluation
- 4.3.2.8. Shopkeepers, markets and birth spacing services
- 4.3.2.9. Using local community organisations
- 4.3.2.10. Using local media and culture and developing appropriate written methods
- 4.3.2.10.i. Puppets as media
- 4.3.2.10.ii. Building on local humour
- 4.3.2.10.iii. Material for new literates or simply written
- 4.3.2.11. Building on local beliefs and ideas
- 4.3.2.12. Building on agricultural concepts relevant to birth spacing
- 4.3.2.13. Focus on youth
- 4.3.2.14. School curricula
- 4.3.2.15. Workers' education
- 4.3.2.16. Use of mass media
- 4.4. Counselling on choice of method for birth spacing/family planning
- 4.4.1. Choosing a method of birth control
- 4.4.2. Methods of birth spacing
- 4.4.2.1. Social policy - late marriage etc.
- 4.4.2.2. Lactation
- 4.4.2.3. Abstinence
- 4.4.2.4. Withdrawal/coitus interruptus
- 4.4.2.5. Barrier methods
- 4.4.2.6. Hormonal methods
- 4.4.2.6.i. Pills
- 4.4.2.6.ii. Injectables
- 4.4.2.7. Intrauterine devices
- 4.4.2.8. Surgical
- 4.4.2.9. Rhythm
- 4.4.2.10. Menstrual regulation
- 4.4.2.11. Abortion
- 4.4.2.12. Cultural factors (shame)
- 4.5. Infertility/subfertility
- 4.5.1. Teaching how babies come to be conceived and born
- 4.5.2. Taking action on subfertility
- 4.6. Keeping up to date with birth spacing/family planning techniques and training methods

5. Immunisation to prevent infectious diseases in children.

- 5.1. The need for immunisation
- 5.2. Schedule and techniques for immunisation
 - 5.2.1. Immunisation schedule
 - 5.2.2. Vaccination techniques
- 5.3. Avoiding the problem of spoiled vaccines and improving the cold chain
 - 5.3.1. 1 out of 3 vaccines may fail because of spoiling
 - 5.3.2. Cold chain teaching materials
 - 5.3.2.1. Keeping up-to-date on the cold chain
 - 5.3.2.2. Looking after your vaccine refrigerator or cold store
 - 5.3.2.3. Cold boxes and vaccine transport care
 - 5.3.3. Vaccine vial use and sterilisation
- 5.4. Packages for teaching planning, organisation and evaluation of immunisation programmes
 - 5.4.1. For district level supervisors
 - 5.4.2. For mothers
- 5.5. Keeping up-to-date with new ideas about immunisation

6. Prevention of MCH disease through promotion of environmental health and hygiene.

- 6.1. Water protection, collection and storage
 - 6.1.1. Safe and effective water collection and distribution
 - 6.1.1.1. Evidence of the influence of clean water supply on reduction of disease
 - 6.1.1.2. Finding and protecting sources of water
 - 6.1.1.3. Community aspects of water supply
 - 6.1.1.4. Keeping up-to-date with water newsletters
 - 6.1.2. Safe and effective water storage
 - 6.1.3. Water purification
 - 6.1.4. Reducing the spread of schistosomiasis
- 6.2. Safe disposal of waste water

- 6.3. Safe disposal of solid waste, rubbish, garbage
- 6.4. Safe disposal of human waste
- 6.5. Housing improvement
- 6.6. Food storage and preservation (see Nutrition
Section 2.2.3.2.)
- 6.7. Home and restaurant hygiene
- 6.8. Prevention of child accidents at home (see Section 8)
- 6.9. Promoting rural development
- 6.10 Reduction of pollution
- 6.11. Health promotion through a healthy life style and
personal habits
- 6.12. Appropriate technology - general source books
- 6.13. Planning, organisation and evaluation of environmental
health services
- 6.14. Keeping up-to-date with new ideas on environmental health,
appropriate technology and community development

7. Care of the sick child.

- 7.1. General sources on care of the sick child
- 7.2. Planning, organisation and evaluation of care of the
sick child
- 7.3. Care of the child with diarrhoea
- 7.4. Care of the child with acute respiratory tract infection
- 7.5. Care of the child with fever
- 7.6. Care of the child with measles
- 7.7. Care of the child with worms
- 7.8. Care of the child with skin problems
- 7.9. Care of the child with red eye
- 7.10. Care of the child with sickle cell disease
- 7.11. Care of the child with wheeziness
- 7.12. Care of the child with tuberculosis
- 7.13. Care of the child with leprosy

- 7.14. Dental care

- 8. Care of the injured child and prevention
 of further accidents especially at home.

- 8.1. General sources of information on accidents, first aid,
 care and prevention

- 8.1.1. Preventing accidents on the road

- 8.2. Child burns, care and prevention

- 8.3. Child poisoning, care and prevention

- 8.4. Child cuts and wounds, care and prevention

- 9. Help with handicap and disability for
 children and mothers.

- 9.1. The problem of disability

- 9.2. General sources on coping with a disability

- 9.3. Help for the child with a mental handicap

- 9.4. Help for the child with a physical handicap
- 9.5. Help for the mother with a disability

- 10. Planning, organisation and evaluation
 of MCH care.

- 10.1. Community diagnosis of health problems, causes of ill
 health and health care resources

- 10.2. Making a plan for provision of better mother and child
 health care

- 10.3. Putting mother and child care plans into action

- 10.3.1. Organisation applicable to all schemes
- 10.3.1.1. Organisation of supplies
- 10.3.1.2. Staff development

- 10.4. Monitoring progress on provision of mother and child
 health care

- 10.5. Learning to work with local services (health and other)
 and local groups involved in community development

11. Learning how to teach others to provide better MCH care.
 - 11.1 What is the teaching-learning process?
 - 11.1.1. What is communication? When does it fail?
 - 11.1.2. How can learning sequences be structured?
 - 11.1.3. What is a problem diagnosis approach to teaching?
 - 11.1.4. How can training programmes for health personnel be planned and evaluated?
 - 11.2. How can we become better teachers?
 - 11.2.1. What makes a good teacher? What can teachers do to help students learn?
 - 11.2.2. Why are attitudes important for teaching?
 - 11.2.3. How can learning material be developed and used in rural areas?
 - 11.2.3.1. Using active learning
 - 11.2.3.2. Recognising the importance of people's facial expressions
 - 11.2.3.3. Pictures, puppets and posters
 - 11.2.3.4. Using distance teaching
 - 11.2.3.5. Other reference material on developing learning materials
 - 11.2.3.6. Equipment for producing low-cost teaching materials
 - 11.2.4. How can teachers ensure feedback from those who are taught?
 - 11.3. What about the learners? How can teaching focus on specific people learning and build on local community beliefs and knowledge?
 - 11.3.1. What encourages people to learn?
 - 11.3.2. What is a problem diagnosis approach to teaching?
 - 11.3.3. What problems need to be avoided (and how) in communicating with people, especially traditional birth attendants?
 - 11.3.4. What learning methods are best for particular individuals?
 - 11.3.4.1. Traditional birth attendant training
 - 11.3.4.2. Teaching local people other than traditional birth attendants
 - 11.3.4.3. Helping health and fieldworkers to communicate with the community in a mass campaign
 - 11.3.4.4. Teaching health centre health workers
 - 11.3.4.5. Teaching district level health workers
 - 11.3.4.6. Teaching national level health workers
 - 11.3.4.7. Teaching in schools and to the general public
 - 11.4. What about the topic being taught? What teaching methods best suit particular subjects?

- 11.5. Keeping up-to-date with teaching methods
- 11.6. Keeping up-to-date with new ideas in community health
- 11.6.1. Newsletters and sources of material on community health
- 11.6.2. Occasional bibliographies on community health



1. Care of mothers in pregnancy and childbirth.



1. Care of mothers in pregnancy and childbirth.

1.1. Antenatal care

1.1.1. Screening of risk cases and provision of appropriate care

1.1.1.1. Recognising mothers at high risk of developing complications during pregnancy

* Aga Khan Health Services and UNICEF (1981) Handbook for lady health visitors and midwives.

Covers antenatal care, the identification of high risk groups and the prevention of common diseases in pregnancy (anaemia and malaria). A useful book, but with few illustrations.

Backett, E.M., Davies, A.M. and Petros-Barvazian, A. (1983) The risk approach in health care. Public Health Paper No.76.

Explains the risk approach, with special reference to maternal and child health, including family planning, as both a method of measuring the need of individuals and groups for care and as a tool for appraisal and reorganisation of health and other services to meet that need. This publication is aimed at senior medical workers and health planners.

Baird, D. (1960) The evolution of modern obstetrics. The Lancet 2 : pp.557-564.

Tells the story of how in Aberdeen "if a woman was short, (possible pelvic disproportion), a fishwife (poor), or had has a dead baby before (history of obstetric problems) she should have special care in pregnancy and should deliver under the close supervision of a trained person". This story holds the essence of the recognition of high risk pregnancies.

* Botswana (no date) Antenatal risk detection card. See Section 1.1.5.2. Organisation of antenatal care.

* Colgate, S.H. et al. (1979) The nurse and community health in Africa: p.103.

Table 4-B: Factors Indicating High Risk Pregnancies

OBSTETRICAL FACTORS	MEDICAL FACTORS
<i>A) In Previous Pregnancies</i> <ul style="list-style-type: none">- Low birth weight babies (< 2.5 kg)- Caesarean section (scarred uterus)- Perinatal death (stillbirth or neonatal death)- Repeated abortions- Extra-uterine pregnancy	<ul style="list-style-type: none">- Anaemia- Malaria- Jaundice- High blood-pressure (13/9)- Amoebiasis, Ancylostomiasis- Sickle cell anaemia (SS)- Renal disease- Cardiac disease- Incompatability of Rhesus or ABO factors
<i>B) In the Present Pregnancy</i> <ul style="list-style-type: none">- Grand multiparity (more than five pregnancies)- Age: 16 years or less Primipara over 30 years old- Unmarried mother, without male support- Weight: over 90 kg Weight: less than 47 kg- History of infertility- Multiple pregnancy- Pre-eclampsia- Postmaturity- Teratogenic viral disease during the first trimester (Rubella, etc.)- Bleeding during pregnancy- Hydramnios	

Table 4-C: Factors Indicating Women to be Referred During the Ninth Month of Pregnancy for Hospital Delivery

<p>Past history of prolonged labour, difficult delivery, or postpartum haemorrhage</p> <p>Estimated foetal size over 4 kg</p> <p>Maternal height under 1.5 m</p> <p>Pelvic malformation</p> <p>Malpresentation (including breech in a primipara).</p>

Fig. 1.1: Part of the excellent Chapter 4: Protecting the health of mothers.

* Dissevelt, A.G., Kornman, J.J.C.M., and Vogel, L.C. (1976) An antenatal record for identification of high risk cases by auxiliary midwives at rural health centres. Trop. Geogr. Med. 28: pp.251-255.

* Essex, B.J. and Everett, V.J. (1977) Use of an action oriented record card for antenatal screening. Tropical Doctor 7: pp.134-138.
This record card uses a 1, 2 or 3 star rating for risk factors, to indicate appropriate management i.e. book for hospital delivery, refer to doctor, refer immediately. The criteria for high risk do

not include healthy primigravidae unless they are under 146cms tall, or multigravidae unless they have had 10 or more pregnancies. In this way a more manageable percentage of women are defined as high risk.

Everett, J. (1984) Obstetric care. British Medical Journal 288: pp.1600-1602.

A short article listing simple practical ideas and appropriate technologies for identifying women likely to have problems in pregnancy and/or labour.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Better maternal and child health. An illustrated manual for dais (traditional birth attendants). A manual which consists almost entirely of line drawings. Three different colours are used for the pages: white pages indicate normal conditions in pregnancy and child birth; yellow pages represent conditions or situations which are risky for the mother, or the baby, or both (e.g. "If you notice any of these conditions, take the woman or the baby to the hospital or health centre for better care than can be available at home"); red pages signify danger or harmful practices ("Avoid such practices. Discourage others from doing such things"). Includes a description of a method for estimating which women may have difficulties during delivery because of their small stature: "Measure the height of the woman with the aid of a bamboo stick. Take a stick. Up to 145cm paint it red. From 145 to 150cm paint it yellow. From 150cm onwards paint it green. Now measure the height of the pregnant woman with your measuring stick. Women who are in the red colour range (less than 145cm) are at risk. Refer them to hospital. Those who come in the yellow range (145-150cm) need special attention. Those who are in its green colour range (above 150cm) need normal care."



Fig. 1.2: Using a measuring stick shaded to indicate women who are at risk.

ICC (1976) The management of pregnancy. Children in the tropics No.105.

Contains on p.25 a similar table to one used by Colgate, S.H. et al. (1976) - see Fig. 1.1. This emphasises the common and important factors of history: of postpartum haemorrhage, caesarean section, prolonged labour, difficult labour and delivery, and premature delivery; age: 16 years or younger, grand multiparity (5 or more children), and secondary subfertility following ectopic pregnancy; medical problems: of sickle cell disease, malaria and amoebiasis, ankylostomiasis.

IPPF (1979) Female circumcision - special report. People 6 (1): pp.24-30.

In some areas severe perineal scarring is an important risk factor. Adhesions from scarred tissue very frequently lead to obstetric complications. Perineal tears during childbirth can lead to recto-vaginal fistulas.

King, M. (ed.) (1966) Medical care in developing countries. The distance from health care and the cost of getting there are important risk factors in many areas. Fig. 24 shows the cost of transport to hospital.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A., and Shah, K.P. (1982) A TBA trainer's kit.

This kit offers a way of developing a systematic training plan for the trainers of TBAs, with particular emphasis on identification of the high risk mother and appropriate referral. The kit comprises material for possible lesson plans, descriptions of training techniques and instructions for making teaching material.

Parent, M.A. and Stroobant, A. (1979) Use of an information collecting stamp in mother and child health centres (in Tunisia). Journal of Tropical Paediatrics 25: pp.162-164.

A rubber stamp has been developed to mark antenatal cards if a mother has oedema or anaemia.

Shah, K.P. and Shah, P.M. (1981) Tri-coloured arm tape for assessing maternal nutrition. Appropriate Technology for Health Newsletter 9 (August) : p.3.

Arm circumference may be used as an indicator of body weight and could possibly be used during pregnancy to identify an at-risk mother, who needs nutritional supplements. A simple "anaemimeter" based on conjunctival colour and haemoglobin level is also reported.

* Werner, D. (1977) Where there is no doctor: pp.282, 256.

HIGH RISK MOTHERS AND BABIES

A note to midwives or health workers and anyone who cares:

Some women are more likely to have difficult births and problems following birth, and their babies are more likely to be underweight and sick. Often these are mothers who are single, homeless, poorly nourished, very young, mentally slow, or who already have malnourished or sickly children.

Often if a midwife, health worker, or someone else takes special interest in these mothers, and helps them find ways to get the food, care, and companionship they need, it can make a great difference in the well-being of both the mothers and their babies.

Do not wait for those in need to come to you. Go to them.

Fig 1.3

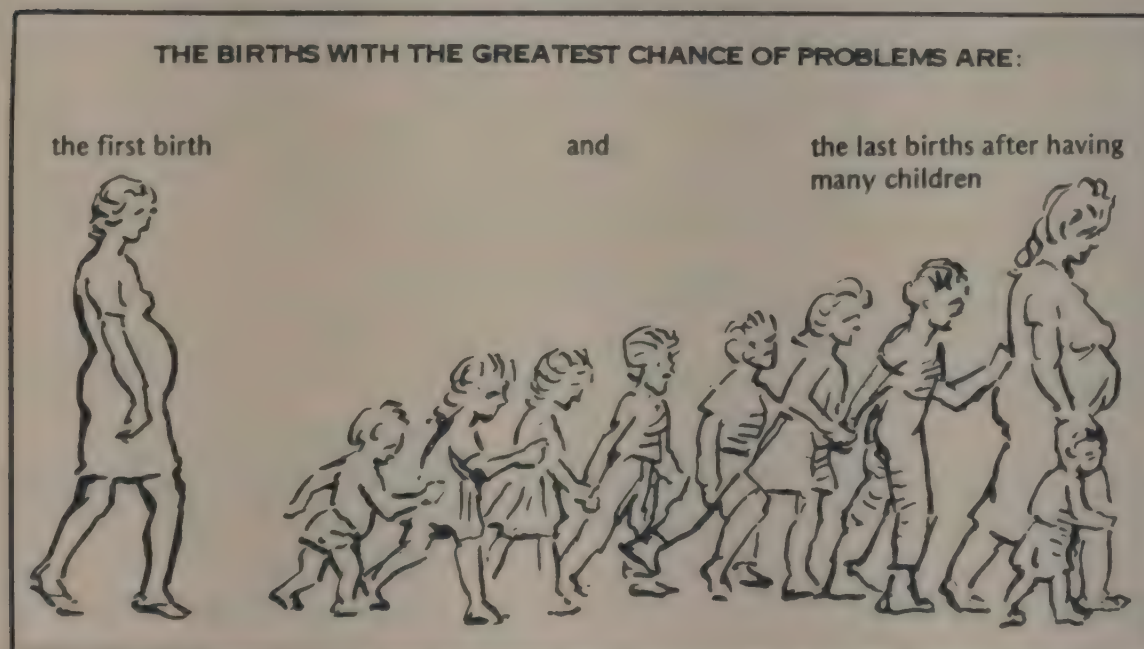


Fig. 1.4.

* Werner, D. and Bower, B. (1982) Helping health workers learn. Contains a useful section on taking an obstetric history.

WHO (1976) Statistical indices of family health. Technical Report Series No. 587.

20 family crises (which may also be risk factors) are listed in Table 1. They include: unwanted pregnancy, death of a child, spouse or parent, war separation, non-support, alcoholism, drug addiction, illegitimacy, imprisonment, institutionalisation for mental illness or mental retardation.

WHO (1981) Risk approach for maternal child health. A selected annotated bibliography. MCH/RA/81.1

About 182 annotated entries, mainly from journals. The subjects

included: identification of risk factors, relative importance of risk factors, method of risk scoring and risk screening, intervention strategies, and health services research.

WHO/BLAT (1985. In press) Facilitating teaching-learning with modules. An approach for nurse-midwife teachers. 2nd revised edition.

Section 10: The first antenatal visit.

Section 11: Return visits for antenatal care.

Section 40: High risk women and infants.

1.1.2.

Providing special care for high risk pregnant women

One of the skills needed by those providing special care for high risk groups is to be able to recognise danger signs, and to know what to do when they appear.

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.

* Philpott, R.H. et al. (1977) Obstetrics, family planning and paediatrics: a manual of practical management for doctors and nurses.

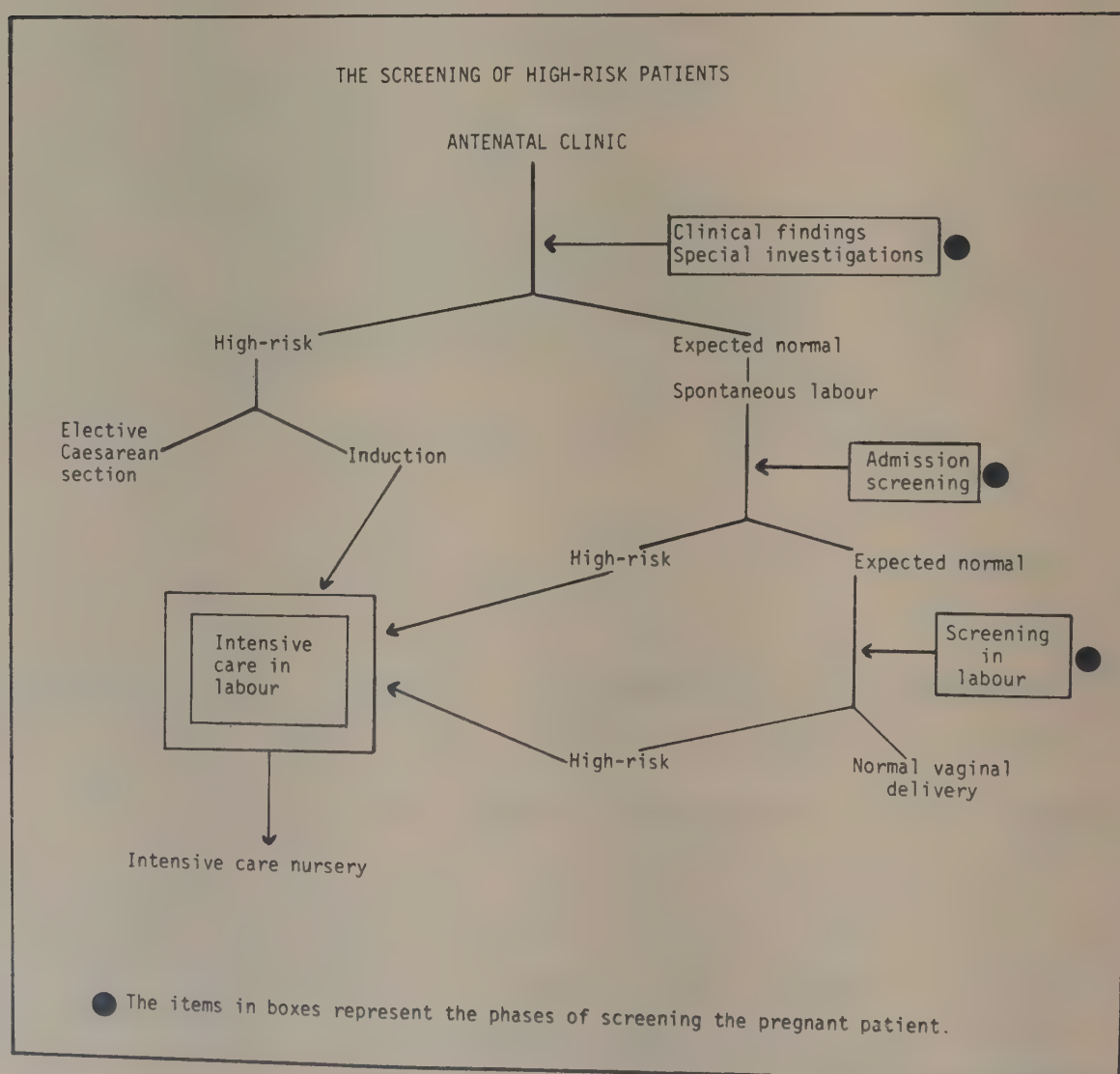


Fig. 1.5. Philpott, R.H. et al (1977): p.56.

- * Werner, D. (1977) Where there is no doctor: pp.250-253. Lists the danger signs that make it important that a doctor or skilled midwife attend the birth:
 - If the women begins to bleed before labour.
 - If there are signs of toxemia of pregnancy.
 - If the women is very anaemic, or if her blood does not clot normally (when she cuts herself).
 - If she has had serious trouble or severe bleeding with other births.
 - If it looks as if she will have twins.
 - If it seems the baby is not in a normal position in the womb.
 - If the bag of waters breaks and labour does not begin within a few hours. (The danger is even greater if she has a fever).

1.1.2. Antenatal tetanus immunisation

- * Jelliffe, D.B. (1974) Child health in the tropics; a practical handbook for medical and paramedical personnel. 4th edition. 170pp. Eng.Sp.

"Where tetanus neonatorum is common, pregnant mothers should be given tetanus immunisation. Two or three doses of tetanus toxoid are given at monthly or greater intervals, from the third or fourth month of pregnancy. If the mother has been immunised (against tetanus) before this pregnancy one dose is necessary. This procedure needs to be accompanied by the education of mothers on umbilical hygiene at birth, which will ultimately make tetanus immunisation of pregnant women unnecessary".

- * Liberia, Ministry of Health and Social Welfare/Christian Health Association (1980) EPI handbook for health workers. Includes pictures of tetanus immunisation for pregnant mothers.

Nambose, J.M. (1981) Immunisation. In Maternal and child health around the world. Edited by Wallace, H.M. and Ebrahim, G.J. Chapter 20: pp.192-199. Gives an immunisation schedule for developing countries, including antenatal tetanus vaccination.

Rahman, M. et al. (1981) Factors related to acceptance of tetanus toxoid immunisation among pregnant women in a maternal-child health programme in rural Bangladesh.

1.1.3. Prevention and treatment of disease/complications during pregnancy

1.1.3.1. Diseases arising or exacerbated by pregnancy (anaemia, malaria, pre-eclampsia)

1.1.3.1.1 Anaemia in pregnancy

- * Ajayi, V. (1980) A textbook of midwifery.

- * Ojo, O.A. and Briggs, E. (1976) A textbook for midwives in the tropics. Chapter 20, Section 5: Malaria and anaemia in pregnancy. Stresses the diagnosis and management of anaemia. There is no

mention of how these conditions can be prevented, but their treatment is described well.

Parent, M.A., and Stroobant, A. (1979) Use of an information collecting stamp in mother and child health centres (in Tunisia). Journal of Tropical Paediatrics 25: pp.162-164.
Anaemia in pregnant women is recognised from pale creases in the palm of the hand and from the mouth mucosa. Each woman's antenatal card is then stamped to indicate any anaemia that has been found.

Platt, B.S. (1962) Tables of representative values of foods commonly used in tropical countries. Medical Research Council Special Report Series No. 302.
Many tropical plants contain iron and folate and could be used more in the prevention of anaemia.

* **Population Reports** (1975) Effects of childbearing on maternal health. Series J No.8.
Covers the causes of anaemia, its consequences and prevention. 160 references.

* **Reid, S.E. and Mola, G.** (1977) Obstetrics for health extension officers.
Chapter 6: Anaemia in pregnancy. "Anaemia is a very serious complication of pregnancy. It will make a woman weak and tired so she cannot work hard in her garden. Then all her family will get hungry and cross. She may die of heart failure. If haemorrhage occurs in pregnancy or at delivery, sudden shock may develop. Then the woman may die. The baby may be very small at birth or die....."

"Anaemia is caused by these things:

1. A diet that does not contain enough iron, folic acid, or protein. (Green leafy vegetables, fish and meat, including tinned meat, will supply all these needs).
2. Malaria.
3. Hookworm.
4. Many pregnancies.
5. Chronic infections and renal disease....."

"Pregnant women should have their haemoglobin checked at the first antenatal visit and again near term.

If iron and folic acid are not given during pregnancy the haemoglobin normally drops by about 20% between 12 and 36 weeks." The chapter continues with instructions on the management of anaemia in pregnancy

- when the Hb is less than 5g% the woman should be referred to a medical officer
- when the Hb is between 5 and 8.5% the woman should be advised about her diet and given iron supplements, folic acid tablets and anti-malarials. If she is more than 36 weeks pregnant she should be referred to a medical officer.

Ross Institute (1978) Anaemia in the tropics. Bulletin No. 11. Section 1 is a general introduction to anaemia. In the tropics this is likely to be due to diet (nutrient-deficiency anaemia), faults in metabolism, excessive loss of nutrients (particularly during pregnancy and lactation when folate may be lost), or to

hookworm infection. Section 2 deals with the diagnosis and treatment of anaemia (medicinal iron, folate, food). The last section covers preventive measures: early recognition through surveys; treatment and/or control of malaria, hookworm and chronic infections; and most importantly, better diet.

This book is useful in drawing attention to the fact that many women may have anaemia caused by hookworm. It may not be advisable to treat the worms during pregnancy because of the possibility of an adverse effect of any drug used.

* VHAI (no date) Anaemia recognition card. Many languages. A card showing photographs of pale lips and tongue (anaemia) and red and healthy lips and tongue. It is designed for use by illiterate workers but it includes simple instructions in English and several Indian languages for use by their teachers.

* VHAI (1977) Better child care. 48pp. Many Indian languages and Eng. Ghanain version also available. Includes the same photographs of anaemic and healthy tongue and lips as in the above card, with suggested dietary advice.

1.1.3.1.ii. Malaria in pregnancy

* Ajayi, V. (1980) A textbook of midwifery. Chapter 6: Diseases that may complicate pregnancy, among them malaria and its prevention and treatment in pregnancy. A checklist of preventive measures is given.

* Ojo, O.A. and Briggs, E. (1976) A textbook for midwives in the tropics. Chapter 20, Section 5: Malaria in pregnancy. Emphasises the treatment of malaria.

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers. "Pregnancy lowers immunity to malaria. Therefore, pregnant women may have repeated attacks of malaria. Malaria can cause: 1) anaemia (this will be more severe in pregnancy); 2) abortion, (miscarriage); 3) premature labour and birth of pre-term babies (these babies often die); 4) small-for-dates or malnourished babies. Mothers in malarious areas should receive anti-malarials during pregnancy. If they develop fever or other acute illness a full course of anti-malarials should be given."

1.1.3.1.iii. Pre-eclampsia (toxaemia)

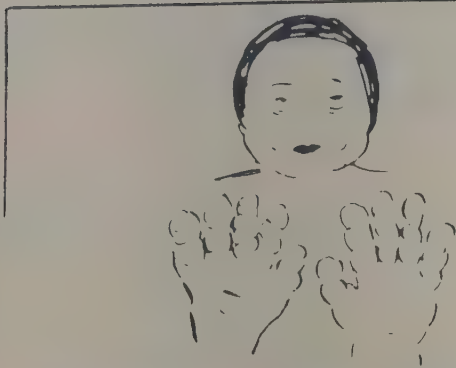
* Alaska, Dept. Health and Welfare. (1966) Midwifery teaching guide for public health nurses.

Describes and illustrates danger signs during pregnancy, e.g. swelling of the face and hands, seeing spots before the eyes, having frequent or persistent headaches, or having cramping pains in the pit of the stomach.

Suggests that the nurse or doctor should be informed, and that the mother, who should lie down for at least 2 hours a day, should cut down on salt and drink two pints of water a day.

Danger Signs During Pregnancy

If These Things Happen To A Mother



Swelling of face and hands



Seeing spots before eyes

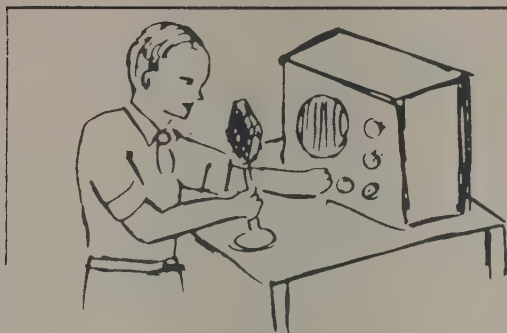


Having headaches often or
headaches that hang on



Having cramping pains in
pit of stomach

Do These Things:



Let the nurse or doctor know



Have mother rest lying down
at least 2 hours a day



Have mother cut down on salt



Have mother drink a quart
of water every day

Fig. 1.6.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Better maternal and child health. An illustrated manual for dais.



Fig. 1.7: Double vision

King, M. (1973) A medical laboratory for developing countries. Section 8-8: Testing the urine for protein, acetone, etc. illustrated.

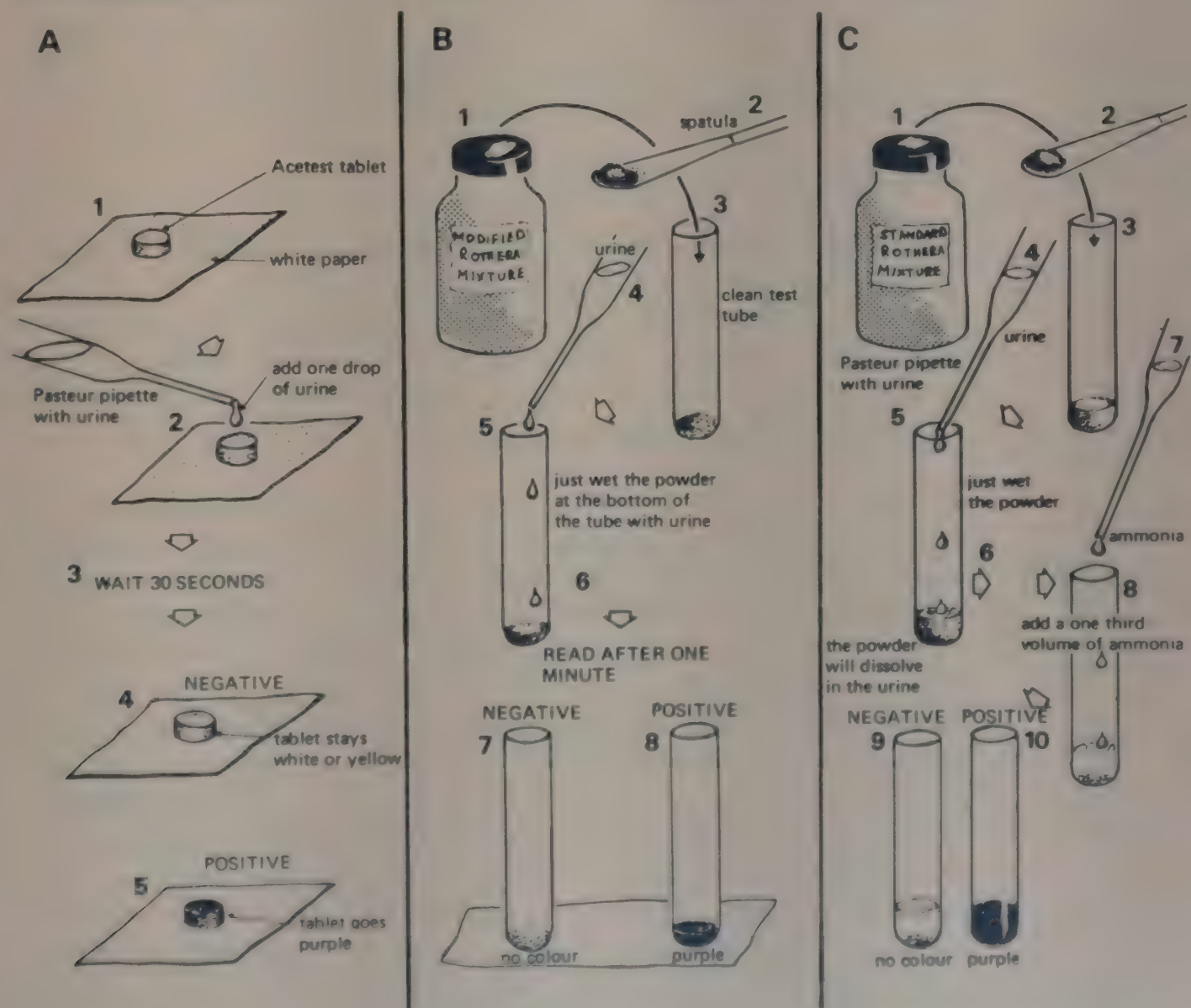


Fig. 1.8: Shows testing of urine for protein, acetone, etc.

Levy-Lambert, E. (1974) Basic techniques for a medical laboratory: pp.387-394.
Detection and estimation of protein in urine.

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

Pre-eclampsia "occurs only in women who are pregnant. It has three signs: generalised oedema, albumen (protein) in the urine, a rise in blood pressure of above 120/80, but only two of these three signs need to be found to make the diagnosis of pre-eclampsia. Pre-eclampsia occurs more often in women having their first baby. The disease does not usually occur before 32 weeks of pregnancy, unless it is a multiple pregnancy. A high blood pressure (150/100 or higher) should be treated in the same way as pre-eclampsia even if the other signs are not present....."

"Rule: If a pregnant woman has generalised oedema the urine must be tested for albumen....."

Management of pre-eclampsia includes: bedrest for the woman; administration of phenobarbitone; careful observation of her blood pressure and the amount of protein in her urine.

"Sometimes the signs disappear quickly. If this happens, the patient should be kept in the hospital or health centre until delivery, or kept nearby and seen weekly....."

"If the signs do not disappear after 48 hours of sedation, or if they get worse at any time, the mother must be referred to a medical officer. If pre-eclampsia is severe and untreated it may cause convulsions. It is then called eclampsia."

1.1.3.2. Recognition and care of complications

1.1.3.2.i Overview of danger signs

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide to public health nurses.

Danger signs during pregnancy are illustrated with simple line drawings. Useful examples are given in Sections 1.1.2. and 1.1.3.2. ii of this bibliography, which could be developed similarly for other countries.

* Gaskin, I.M. (1977) Spiritual midwifery: p.116.

"Danger signs: All women need to be told at their first antenatal visit that certain signs will tell them that a serious problem may be occurring. Pregnant women should seek medical help immediately if any of the following appear: bleeding, severe headaches, spots before the eyes, blurred vision, swelling of the face and hands, fever or chills, abdominal pains and vomiting beyond the first trimester. In the first trimester bleeding may be a sign of miscarriage, and ectopic pregnancy, or cervicitis. Bleeding in association with abdominal cramping usually means a miscarriage or an ectopic pregnancy. Severe headaches before the 20th week of pregnancy may indicate a hydatidiform mole. After the 20th week of pregnancy they may be a sign of toxæmia. Spots before the eyes and blurred vision as well as swelling of the face and hands are also signs of hydatidiform mole or toxæmia. Fever and chills usually mean infection. Any infection in the mother predisposes

the baby to an infection soon after birth. All fevers need to be investigated and treated promptly.

As already stated, abdominal pain in the first trimester is a sign of an ectopic pregnancy or an abortion.

At any other time during pregnancy, it can be a sign of conditions that happen to a woman at any time during her life. These include an ovarian cyst, appendicitis and hepatitis, etc. If abdominal pain is accompanied by bleeding in the last trimester the midwife should think of an abruptio placenta. Vomiting that lasts beyond the first trimester may be a symptom of hyperemesis gravidum or a symptom of hydatidiform mole. Any time any of the seven signs that have been discussed here appear during pregnancy, the pregnant woman should seek medical help immediately."

* Zaire, Bureau d'etudes et de recherches pour la promotion de la sante. (1976) Maternite et sante; notions d'obstetrique. Fr. Chapters 9, 10, 11, 12 and 13 deal with anomalies in pregnancy. These include hyperemesis gravidarum, ectopic pregnancy, multiple pregnancy. Eclampsia is dealt with in Chapter 14 which also includes pre-eclampsia.

1.1.3.2.ii. Vaginal bleeding during pregnancy

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.

Simple line illustrations to show that if there is bleeding from the birth passage, cramping pains in the lower abdomen or a feeling of weakness or faintness, the mother should go to bed and stay there and the doctor or nurse should be notified. Similar drawings could be useful for other countries.

.....Danger Signs During Pregnancy(cont.)

If These Things Happen To A Mother

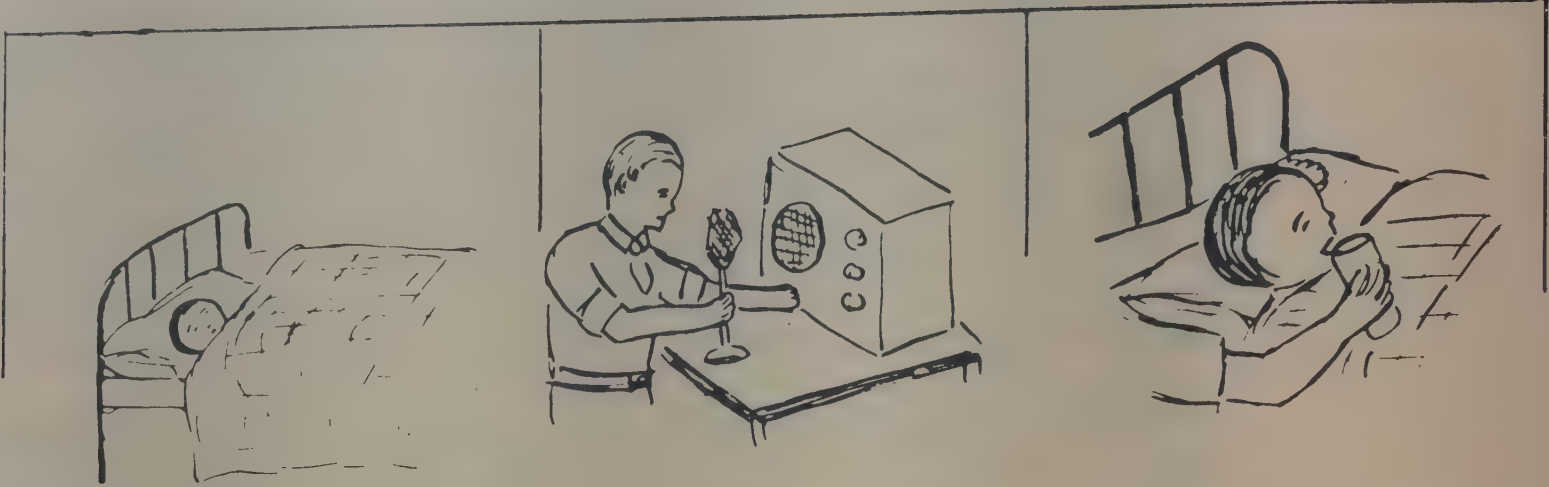


Bleeding from birth passage

Cramping pains in lower abdomen

Feeling of weakness or faintness

, Do These Things:



**Have mother
go to bed and
stay there**

**Notify Doctor or
nurse at once**

**Give mother lots
to drink, but not
tea or coffee**

Fig. 1.9.

Gaskin, I.M. (1977) Spiritual midwifery.
Some causes of miscarriage are listed on p.415.

"Defective egg or sperm.

Unfavourable implantation site.

Failure of the cells forming the embryo to divide and differentiate properly.

Failure of the corpus luteum to produce its hormones.

Failure of the placenta to function, either in nourishing the baby or producing its hormones.

Infections the mother may have - high blood pressure, hyper - or hypo-thyroidism, some vitamin deficiencies, malnutrition, diabetes, and others.

Uterine defects, such as a double uterus, scar tissue, or a tumour. Incompetent cervix i.e. a cervix that will not stay closed once the baby is putting a certain amount of pressure on it. It opens, usually in the second trimester, and the baby, who may be too immature to survive, is born. Incompetent cervix can be a cause of repeated late miscarriages or premature deliveries. It may be caused by trauma to the cervix during previous deliveries or surgery, or it may (rarely) be congenital. A doctor can sew up the cervix of a woman with this condition, usually between the fourteenth and eighteenth week of pregnancy. The doctor will then open the cervix when it is time for the baby to be born.

Exposure to toxic chemicals in the environment."

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

"Vaginal bleeding during pregnancy is always serious. There are two common conditions to think of. These are:

EVALUATING THIRD TRIMESTER BLEEDING

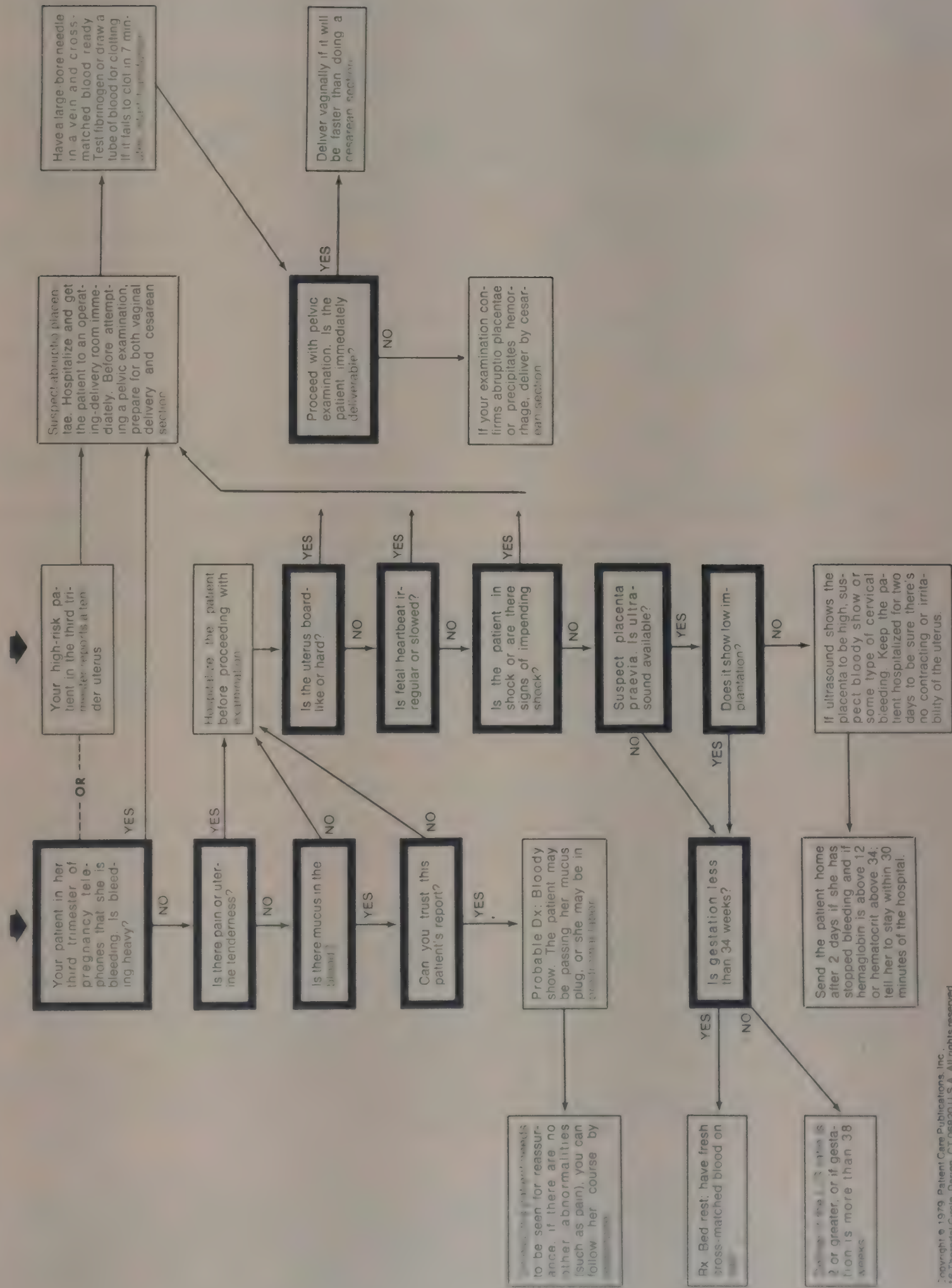


Fig. 1.10

(a) Abortion (miscarriage) - uterus less than 24 weeks (fundus below umbilicus or not palpable).

(b) Antepartum haemorrhage - uterus bigger than 24 weeks. Therefore, the first thing to do if a woman has vaginal bleeding is to feel the abdomen and find out how big the uterus is"

"Abortion. Most abortions occur in the second or third month of pregnancy. About 10% of pregnancies end in abortion. Abortion is often begun by an infection like malaria or pneumonia causing fever. Therefore, check always for signs of medical illness and treat if found.

There are two kinds of abortion; threatened abortion when the foetus is still alive and inside the uterus and incomplete abortion when the foetus is dead or has already passed out. It is important for the HEO to tell the difference between threatened abortion and incomplete abortion; the management of the two conditions is quite different"

"If the bleeding occurs without any pain, the uterus may stop contracting and the foetus may live. This is a threatened abortion. The cervix will remain closed"

The recommended management of this condition consists of bedrest, sedation, a full course of antimalarials, and treatment of any existing infection.

"If heavy bleeding occurs with pain like labour pains, the foetus will die and the pregnancy will be lost The cervix will be a little open, usually about 20cms. This is an incomplete abortion".

The HEO is advised to: administer ergometrine and syntocinon; pass a speculum and remove any tissue in the cervical os (mouth of the cervix) with sponge forceps before giving oxytocin or repeating ergometrine; treat the patient for shock as necessary; transfer her immediately to a health centre if there is heavy bleeding which does not stop; give a full course of anti-malarials and also antibiotics if the patient has a fever or foul-smelling vaginal discharge; transfer the patient if there is still bright bleeding after five days.

"Antepartum haemorrhage. This is vaginal bleeding occurring after the 24th week of pregnancy. Never do a vaginal examination if a woman has had an antepartum haemorrhage, you will only make the bleeding worse"

If the blood loss is small, the HEO should: give morphine and chlorpromazine; arrange for the patient to be transferred to the health centre, and make sure that she rests in bed until the transfer takes place. If the blood loss is heavy, the patient may need to be treated for shock. She should also be given morphine and transferred urgently to a health centre.

"If the uterus is hard and tender, there has been a lot of bleeding inside the uterus. Several litres of intravenous fluid will be necessary to treat the shock".

* **Werner, D.** (1977) Where there is no doctor. p.281: Miscarriage (spontaneous abortion): It is explained that miscarriages are most likely in the first three months of pregnancy and usually occur because the baby is imperfectly formed. The instructions for coping suggest that if there is no heavy bleeding the condition should be treated with the same care

and precautions as birth. If there is heavy bleeding or the bleeding continues for many days the woman should stay in bed until it stops. A few days afterwards," a simple operation may be needed to clean out the womb (dilation and curettage, or D and C)". Specific instructions for coping with extremely heavy bleeding are given on p.266. Fever or other signs of infection should be treated as for childbirth fever: p.276.

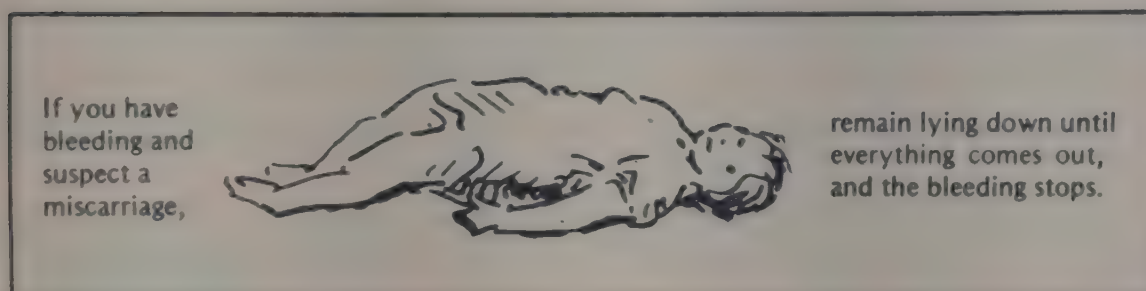


Fig. 1.11.

1.1.3.2.iii. Convulsions in pregnancy (and labour)

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

Convulsions during pregnancy may mean: eclampsia, cerebral malaria, meningitis, or epilepsy. During a convulsion the HEO should:

"1. Keep the patient's airway clear by sucking her out and turning her on her side. 2. Stop her biting her tongue. An ordinary stick is useful for this purpose. 3. Control violent movement. 4. Give paraldehyde 8mls. I.M.I.

After the convulsion: 1. Give morphine 10 mg. I.M.I. and diazepam 10mg. I.V. 2. Give chloroquine intramuscularly. 3. Look for signs of meningitis..... (and) treat..... 4. Contact a medical officer. Note: Do not transfer the patient until the convulsions have been controlled."

1.1.3.2.iv. Genetic problems

Bundy, S. (1979) Clinical genetics.

A set of 24 slides, with script. A cassette tape is also available. The first 13 slides deal with inheritance by a single gene, family patterns and genetic counselling. The second 8 slides describe polygenic inheritance. The last 3 slides deal with genetic counselling in Down's Syndrome (mongolism).

1.1.3.2.v. Twins

* Everett, J. (1981) Twin pregnancy and labour.

This set of 24 slides and script (cassette tape is also available) is about the management and complications of twin pregnancy and labour. It aims to help midwives and medical students. Slides 1-7 deal with types of presentation of twins; slides 8-12 are about pregnancy problems with twins; slides 13-20 deal with

delivery and management of the second twin; slides 21-23 deal with prolonged retention and 'locked twins'; and the last slide shows how to breastfeed twins.

1.1.3.3. Harmful effects of drugs in pregnancy

- * Gaskin, I.M. (1977) Spiritual midwifery.
- * Werner, D. (1977) Where there is no doctor.

1.1.4. Antenatal education for pregnant mothers (and fathers)

1.1.4.1. The first nine months of life (conception and growth in utero)

- * Camera Talks Ltd. (no date) Filmstrip of photographs by L. Nilsson et al. (see below)
In use in many antenatal clinics in the UK.
 - * Demarest, R.J. and Sciarra, J.J. (1969) Conception, birth and contraception, a visual presentation.
Clear line drawings. Very useful when models or photographs may make people embarrassed.
 - * Family Doctor Publications (annual) You and your baby, Part 1: Pregnancy to birth.
 - * Howard, G. (1975) Physiology of women: Menstruation, conception and pregnancy.
A set of 24 slides with script. A cassette is also available. The slides show the structure (anatomy) and the function (physiology) of the female reproductive organs, how and when menstruation starts, how and where fertilisation of the egg and the sperm occurs, the changes that occur in the mother, and the development of the foetus into a baby. The pictures are mostly colour drawings.
 - * Llewellyn-Jones, D. (1972 or later edition) Everywoman, a gynaecological guide for life.
Clear line drawings and description month by month through pregnancy.
 - * Nilsson, L., Ingleman-Sundberg, A., and Wirsén, F. (1967) The everyday miracle, a child is born.
An amazing set of photographs which show the live foetus in utero, changing week by week, month by month during pregnancy.
- Zaire, Bureau d' études et de recherches pour la promotion de la sante (1976) Maternité et sante: notions d' obstétrique: p.35.

1.1.4.2. Harmful habits in pregnancy

- * Miller, M. (1978) Tomorrow's epidemic (tobacco and the third world).
Reviews the dangers of the spread of cigarettes in the third

world. The relationship of smoking to health (association with cancer, bronchitis, heart disease) is summarised. It is unfortunate that there is no study of smoking and pregnancy since there is now evidence that smoking mothers have low birth weight offspring.

However, the book is a good introduction to the subject. Smoking is clearly a risk factor in pregnancy.

The most tragic victims of cigarettes are potentially the babies of mothers who smoke. Pregnant women who smoke are more likely to have:



- underweight babies (less than 5½ lbs. or 2.5 kg.)
- shortened gestation (less than 38 weeks)
- spontaneous abortions (special-ly during the last months of pregnancy)
- complications of pregnancy and labor (including premature rup-ture of membranes, bleeding during pregnancy and placenta previa and abruptia)
- higher rates of perinatal mor-tality (still births and newborn deaths)

Fig. 1.12: TCHU (no date) Smoking pregnant lady.
This picture may be reproduced.

1.1.4.3.

Keeping fit in pregnancy, avoiding back strain

Croydon, Health Education Department, UK (no date) Post-natal exercises.

A useful leaflet prepared by the Obstetric Association of Chartered Physiotherapists.

Start with 6-8 movements gradually increasing

1 1st - 3rd DAY LYING ON BACK



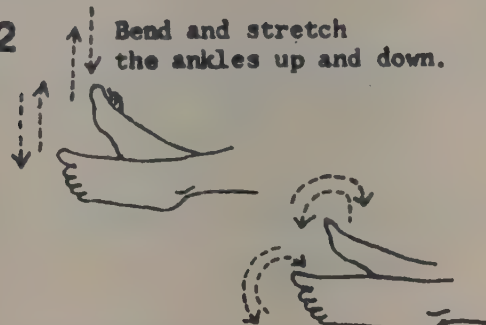
Put hands on rib cage, breathe in breathing sideways against hands. Breathe out, squashing the air out.

5 FOR THE WAIST LINE 4th - 8th DAY



Keep the bent leg still - make the straight leg shorter by drawing it up from the Hip and Waist. Then make it longer by stretching down. Repeat with other leg.

2 Bend and stretch the ankles up and down.



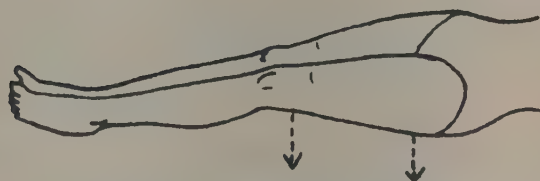
circle the ankles

6 FOR THE FRONT OF THE TUMMY



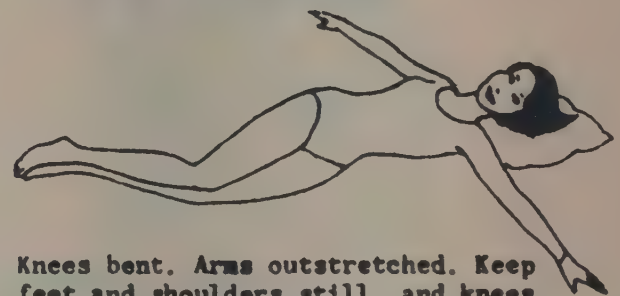
Tighten tummy muscles by pulling in, and press Waist downwards against bed.

3



Press backs of knees and thighs down onto bed and relax.

7 FOR THE WAIST AND HIPS



Knees bent. Arms outstretched. Keep feet and shoulders still, and knees together. Drop knees to alternate sides.

4

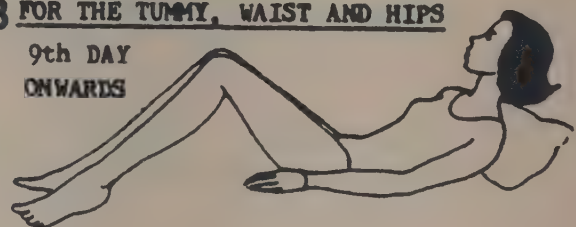


Knees bent-squeeze buttocks together and tighten inside as if you are trying to stop passing urine. Get into the habit of doing this up-lifting movement OFTEN in sitting and standing as well.

*CAESAREAN SECTIONS EXS. 1 - 4

8 FOR THE TUMMY, WAIST AND HIPS

9th DAY ONWARDS



Lying on back with arms at sides; lift head off pillow and down.

Fig. 1.13.

* McKenna, J., Polden. M., and Williams, M. (1980) You, after childbirth, exercises and advice for the new mother. 33pp. Written by obstetric physiotherapists for the UK, but equally useful elsewhere because of the clear line drawings and easy to follow instructions.

* McLaren, J. (?1980) Preparation for parenthood; notes for use in antenatal classes.

Montgomery, E. (1969) 3rd edition. At your best for birth and later.

Includes preparation for labour.

* Mother and Baby (no date) Sex in pregnancy. Advice pamphlet No.13.

* National Childbirth Trust, UK (no date) Keeping fit for pregnancy and labour. Leaflet.

* Noble, E. (1980) Essential exercises for the childbearing year, a guide to health and comfort before and after the birth of your baby.

Includes clear line drawings.

* Okiki, G.A. (no date) How to care for yourself during pregnancy. 13pp. Mimeo.

A short well-illustrated booklet written for pregnant women (in Africa) attending the health centre. Emphasises the value of exercise, sleep and rest, physical activity and nutrition. A good example of what can be produced to meet local needs.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

1.1.4.4.

Nutrition in pregnancy

* Ajayi, V. (1980) A textbook of midwifery.

Chapter 6 of the book details the diseases that complicate pregnancy - among them anaemia and malaria. After exploring the forms of anaemia, it gives a checklist for preventing anaemia, particularly in pregnant women.

Boston Women's Health Book Collective (1979) Our bodies, ourselves, a book by and for women.

Chapter 5: Taking care of ourselves - about nutrition, particularly for affluent societies, e.g. "Take less of these calories" (sugar, fat, salt and refined carbohydrates) and "Take more of these calories" (fish, liver and chicken, vegetables, whole grain etc.). A section on "How to read labels" on commercial products is included to help readers avoid preservatives, colourings and artificial flavourings.

* Ebrahim, G.J. (1983) Nutrition in mother and child health. Chapter 2: Nutrition in pregnancy and the growth of the foetus.

* Goldbeck, N. (no date) As you eat, so your baby grows, a guide to nutrition in pregnancy. 16pp. Illustrated. Very useful, simple booklet, written for the USA, but the comprehensive information is very relevant everywhere.

Hosken, F.P., Williams, M.L. and Garrant, M.L. (1981) The

universal childbirth picture book.
Includes an illustration of "The food we need to grow a healthy baby."

Mata, L.J. (1978) The children of Santa Maria Cauque. A prospective field study of health and growth.
Reference material. A study of the effects of the maternal environment, including diet in pregnancy, on the health and growth on infants.

* **Shah, K.P.** (1981) Maternal nutrition in deprived populations. Assignment Children 55/56: pp.41-72. (Reprint).
Reference material.

* **Fig. 1.14 TCHU** (1981) The cycle of undernutrition. Picture by Morley, D.C. This picture may be reproduced.

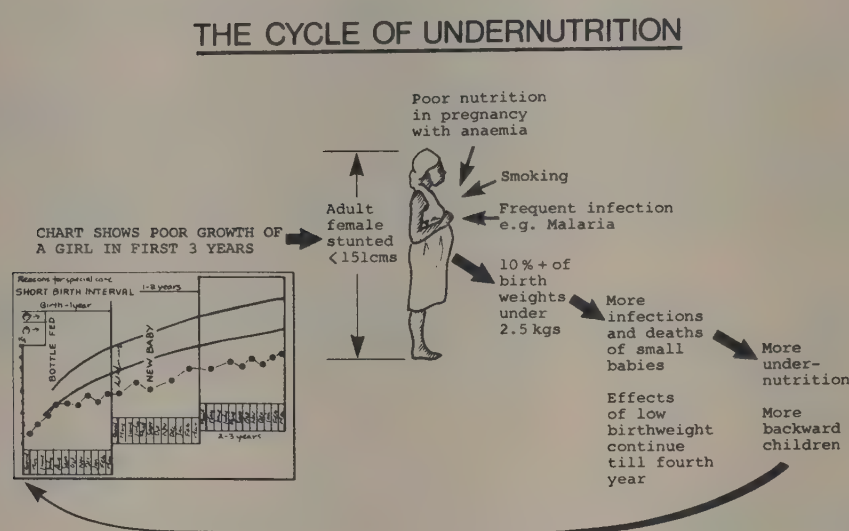


Fig. 1.14.

* **VHAI** (1977) Better child care. 48pp. Many Indian languages and Eng.
Small booklet with photographs that can be used for one to one teaching in the village. The booklet is intended as a memory aid for the worker as well as a teaching aid. Includes: anaemia recognition from tongue (may be easier than conjunctiva), handwashing and knife sterilising in the fire prior to delivery of babies, infant feeding.
Ghanaian version also available.

* **VHAI** (1978) Teaching village health workers, a guide to the process: a teaching pack.
Lesson plan unit III: Antenatal, maternity and postnatal care. Contains the advice that: (1) a pregnant woman in rural India should eat more than she eats normally; (2) a pregnant woman should eat some green leafy vegetables every day; and (3) early recognition of danger signals in pregnancy, indicating possible complications, can save a mother's life. Each lesson plan covers what to teach, and how to teach and review it, with suggestions for practice by the village workers.

* **Werner, D.** (1977) Where there is no doctor.

Includes a very useful nutrition section.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse-midwife teachers. 2nd revised edition.

Section 13: Health and nutrition education in pregnancy.

Section 17: Nutrition in pregnancy.

* Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (no dates) Booklets: Pour que mon bebe naisse en bonne sante (Booklet 18); Le sang et l'anemie (Booklet 19); La maternite et la promtion de la sante (Booklet 31).

1.1.4.5.

Danger signs in pregnancy

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.
Includes simple line illustrations.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainers kit.

Includes a section on risk factors in pregnancy. Identifies the danger signs that require rapid referral and risk conditions that require further assessment.

* Werner, D. (1977) Where there is no doctor.

See pp.250-252; Describes danger signs in pregnancy. See Section 1.1.3.1. of this bibliography.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse-midwife teachers. 2nd revised edition.

Includes sections on anaemia in pregnancy; vaginal bleeding and high blood pressure.

1.1.4.6.

Teaching pregnant mothers about using maternity services

Okiki, G.A. (no date) How to care for yourself during pregnancy. Mimeo.

The front cover has a line drawing implying "come to the health centre when you are pregnant".

* Scottish Health Education Group (1980) The book of the child (pregnancy to 4 years old).

The chapter on medical care in pregnancy answers questions that many women ask at the first antenatal visit. This is part of an excellent book designed for expectant parents.

1.1.4.7.

Teaching mothers about labour and delivery

Barnabas, G. (1982) Pregnancy and childbirth. Tigrinya.

* Inch, S. (1982) Birthrights, a parents' guide to modern childbirth.

See Section 1.2.6. of this bibliography.

IPPF (1971) The use of pelvic models in family planning programmes. 18pp.

Lays down criteria for the selection of a suitable model. Describes six models and assesses them on the basis of: the audience for which they are most appropriate; which demonstrations can be done well or fairly well on them; which demonstrations cannot be done on the models; their suitability for fieldwork demonstrations (not too fragile, not too bulky, not too heavy); the accuracy of the anatomical modelling (e.g. are the proportions correct?); and construction problems (which components tend to come apart?).

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit.

Shows how to make the "Ilfra Doll", a simple doll which fits in a uterus-like bag. It is of particular use in demonstrating the second and third stages of labour and the importance of waiting for the neck of the womb to open before pushing starts.

"At the beginning of labour the baby is inside the bag of water and the opening at the bottom end is tightly closed. You think that you can force an opening by pushing. This is not so. The opening at the bottom of the bag which holds the baby must be as large as the baby's head before pushing begins. Now I will show how that opening takes place and why pushing too early is really dangerous.'

Produce the Ilfra doll in its bag with the drawstring held to keep the opening closed. Let each TBA feel the doll's head and as they do so comment on its hardness and ask the question: 'Can that head get through that closed opening?' Keeping the drawstring tightly held, demonstrate that pushing from the top of the bag on to the doll does not produce an opening. Remind the TBAs that the closed opening is soft and fleshy like our lips, and ask them what happens if something hard is banged against our lips. (This can be acted out using a tea bowl or similar object that may be handy). With a little prompting, the TBAs will produce the information that the lips will get sore and will then begin to swell, so that it will be difficult to open the mouth. And so if the head of the baby is forced repeatedly against the closed opening to the birth passage, it will become more difficult for it to open.

Tell the TBAs that this tightly-closed exit does open naturally during the first stage of labour until it is big enough for the baby to pass through. Picking up the bag again, explain that the opening will happen because the sides of the bag are pulled up and get shorter. Demonstrate this by pulling up the sides and middle of the bag by turn, gently with both hands. With each pull up show the results of the slowly-widening exit, saying 'Can the head pass through that?' until the point is reached when the answer is: 'Yes, so now the mother must use her contractions to push the baby out'. Instruct the woman to hold her breath, instead of relaxing with her contraction, and to use her natural urge to push to the full. Remind the TBAs again never to ask the mother to bear down or push until the opening is wide enough to let the baby through."



Fig. 1.15: The Ilfra doll

Note

"When finished, the doll and placenta should fit snugly into the bag. It may be preferred to make the bag first and then test the head size in relation to it. In practice, it is found that the head generally takes up about $\frac{3}{4}$ of the width of the bag."

- * Maternity Center Association (no date) How to make a knitted uterus for teaching.

This has been found to be particularly helpful for parents so that they can understand how labour contractions work. Photographs show how the knitted model illustrates first a long thick and closed cervix, then a partially dilated cervix, followed by a complete dilatation.

How to Make a KNITTED "UTERUS" for Teaching

Many fine teaching aids are available commercially for the teacher of parents classes: films, charts and records; but occasionally the instructor finds that she can construct something herself which will make interpretation particularly effective.

We have found that parents readily understand how labor contractions work when we use a stuffed, knitted "uterus." By compressing the "fundus" it is easy to illustrate the effect of labor contractions—the downward push against the baby and the upward pull on the cervix. In this way, effacement and dilatation are readily visualized.

The size of the "uterus" should be appropriate to the size of the instructor's hands. A person with large hands or long fingers will use the large size; a person with small hands will find the smaller size more comfortable. Since this is merely a representation, there is no attempt to make this visual aid lifelike in appearance. Actually, it may be more acceptable to the class if it does not appear to be too realistic.

Following are directions for knitting a "uterus." The numbers in parentheses are for the larger size.

MATERIALS NEEDED: Knitting worsted, 2 ounces
1 set double-pointed needles, size 6
1 doll's head or child's ball, 3½ inches in diameter
Old stockings or cloth for stuffing
Rayon seam binding or ribbon, 16 inch length

DIRECTIONS: Cast on 48 sts. Divide evenly on three needles. Join. K2, P2 until cuff measures 2 inches. First round, incr. 1 st. in every 6th st. - 56 sts. K evenly for 6 (4) rounds. 8th (6th) round, incr. 1 st. in every 7th st. - 64 sts. K evenly for 6 (4) rounds. 15th (11th) round, incr. 1 st. in every 8th st. - 72 sts. K evenly for 6 (4) rounds. 22nd (16th) round, incr. 1 st. in every 9th st. - 80 sts. K evenly for 6 (4) rounds. 29th (21st) round, incr. 1 st. in every 10th st. - 88 sts. K evenly for 6 (4) rounds. 36th (26th) round, incr. 1 st. in every 11th st. - 96 sts. K evenly for 6 (4) rounds. 43rd (31st) round, incr. 1 st. in every 12th st. - 104 sts. K evenly for 6 rounds. (For larger size, continue knitting 104 sts. evenly for 5 inches).

DECREASE: First needle *K 11 sts., slip, K, pass, repeat from * for entire round. Next round, *K 10 sts., slip, K, pass, repeat from * for entire round. Next round, *K 9 sts., slip, K, pass, repeat from * for entire round. Next round, *K 8 sts., slip, K, pass, repeat from * for entire round. Next round, *K 7 sts., slip, knit, pass, repeat from * for entire round. Next round, *K 6 sts., slip, K, pass, repeat from * for entire round. Next round, *K 5 sts., slip, K, pass, repeat from * for entire round. Next round, *K 4 sts., slip, K, pass, repeat from * for entire round. Next round, *K 3 sts., slip, K, pass, repeat from * for entire round. Next round, *K 2 sts., slip, K, pass, repeat from * for entire round. Next round, *K 1, slip, K, pass, repeat from * for entire round. Next round, * slip, K, pass, repeat from * for entire round.

FINISHING: Draw yarn through remaining 8 stitches and fasten. Stuff with stockings or cloth. Insert doll's head or ball. Weave seam binding or ribbon through "external os," to control opening.



Cervix long, thick and closed



Cervix partially dilated, effacement almost complete



Dilatation and effacement completed

National Childbirth Trust, UK (no dates) Leaflets.
Titles include Breathing during labour, Twins, and A guide to labour for expectant parents. This is divided into several parts: What is happening?; Helping yourself; and Husband's, our friend's, help". A useful leaflet for expectant fathers is also available.

Niger, Department de Dosso, direction departementale de la sante. (1977) (1) Guide pour la formation des matrones; (2) Aide memoire pour la formation des matrones (intended for illiterate village midwives).

Pathfinder Fund (no date) Low cost pelvic model.
Not yet related to the IPPF evaluation of six pelvic models.
(See above)

* Sudan, Family Planning Association (no date) Local doll for teaching obstetrics.

* Williams, M. and Booth. D. (1980) Antenatal education. Guidelines for teachers. 2nd. edition.
The aim of this book is to build up mothers' confidence in themselves through knowledge and understanding of their ability to trust and control their body during labour. It also aims to bring about a healthy and happy pregnancy, childbirth and rehabilitation after birth, and to assist in the bonding of the baby with its parents by preparing the parents physically and emotionally both before and after childbirth. The book addresses itself to the UK public, but could be a useful reference for other countries.

* WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse-midwife teachers. 2nd revised edition.
Includes sections on normal and abnormal labour.

1.1.4.8.

Teaching pregnant mothers (and some fathers) about care of the newborn

Little information directed at pregnant mothers has been found.

* Forbes, R. (?1980) Father to be.

* Gordon, G. and Gordon, S. (1981) Nutrition and child health flannelgraphs.
These flannelgraphs and scripts cover 7 topics: Using flannelgraphs; Come to the child welfare clinic; Measles; Learning to eat; Feed your child three times a day; Diarrhoea prevention; and Home management. Designed for the Savannah area of West Africa.

* Health Education Council, UK (no date)
(1) You know more than you think you do.
(2) Now you're a family.

* Leach, P. (1977) Baby and child from birth to 5 years.
Excellent section on "the unsettled newborn baby".

* National Childbirth Trust, UK (no date) Caring for the new baby. Leaflet.

* Ojo, O.A. and Briggs, E. (1976) A textbook for midwives in the tropics.
Section 4, pp.85-140 is on antenatal care. A check list for midwives in Chapter 11 - "Clinic talks" - deals with normal pregnancy, preparation for confinement, care of the newborn, infant feeding and postnatal examination. Nutrition in pregnancy is also mentioned.

* Scottish Health Education Group (1980) The book of the child (pregnancy to 4 years old).
Practical suggestions on how to involve the older child in care of the baby and thus avoid jealousy. A section on "you and your baby", includes such topics as "why do babies cry?"

* WHO (1973) Health education manual for midwives. Mimeo only available?
Many useful ideas.

1.1.4.9.

Teaching pregnant mothers about breastfeeding

Close, S. (1972 reprinted 1976) The know how of breastfeeding. A simply written book presented in question and answer style, for British mothers. It provides advice on most of the problems of breastfeeding but still teaches limiting the sucking time during the first few days.

* Croydon, Health Education Dept. (1983) Breastfeeding: the first few days. Leaflet. Also, Why breastfeed?

* Health Education Council, UK (no date) Breastfeeding. Leaflet.

* How to survive the first week of breastfeeding. Health Education Council, UK (1978?)
Pamphlet for first time mothers, which is rather rigid about what will happen on specified days. However, it is amusingly illustrated and can be useful.

Helsing, E. and Savage King, F. (1982) Breastfeeding in practice; a manual for health workers.
A manual written for health workers in both developing and industrialised countries, to enable them to give well informed advice to mothers on all aspects of breastfeeding including: how breastfeeding works; antenatal preparation; problems and what to do; the effect of diet, drugs and illness; mechanical aids; relactation; and popular myths about breastfeeding, both harmful and harmless.

* National Childbirth Trust, UK (no date) Why breastfeed? Leaflet.

* WHO (1979) Breastfeeding. Booklet. Eng. Fr. Sp. Port. Arabic.

Although designed for the primary health worker, this could well be used for antenatal teaching for mothers. It deals with preparation for breastfeeding, nutrition of the mother, weaning and child spacing. The booklet could be translated into local languages. Illustrated in colour.

1.1.4.10

Teaching pregnant mothers about birth spacing

See Section 4.2 on the health benefits of birth spacing.
See Section 4.4.1 on choosing a method of birth spacing.

* Ajayi, V. (1980) A textbook of midwifery.
Chapter 12 is about family and public health. It contains a detailed description of family planning methods that includes the role of traditional birth attendants, domiciliary midwives and family doctors in family planning.

1.1.4.11

Teaching pregnant mothers about child development

* Illingworth, R.S. (1981) Your child's development in the first five years. 72pp.

* Scottish Health Education Group (1980) The book of the child (pregnancy to 4 years old).

1.1.5.

Planning, organisation and evaluation of antenatal care

1.1.5.1.

Planning antenatal care

Afghanistan, Ministry of Public Health (1977) Basic health centre manual.

The components of antenatal care are listed: history, physical examination, urine and haemoglobin assessment, health education on the danger signs in pregnancy, family planning suggestions, and advice on nutrition and diet: p.202.

Aletor, G.A. (1981) Domiciliary midwifery care, including traditional birth attendants. In Wallace, H.M. and Ebrahim, G.J. (eds) Maternal and child health around the world. A Nigerian study comparing traditional birth attendants and trained midwives. The author recommends the training of traditional midwives and the provision of a midwifery kit to promote aseptic delivery. TBAs could be used for health education promotion on subjects such as infant feeding, family planning and nutrition.

Bialestock, D. (1973) Child care: China 1972. Medical Journal of Australia (Sydney). 2: pp.979-980.
Describes the author's observation of Chinese children in communes, day-care centres, kindergartens, schools and hospitals. Social policy in China includes nursing mothers being allowed two breaks in a working day to breastfeed and 56 days of paid leave in pregnancy. In many countries working women are given time to attend antenatal care without losing pay.

Colgate, S.H. et al (1979) The nurse and community health in Africa.

Chapter 4: Protecting the health of mothers. The objectives of antenatal care are spelt out clearly. Regular check ups during pregnancy; the detection of high risk pregnancies; the prevention of common complaints during pregnancy (anaemia, malnutrition, malaria); education on child feeding and child rearing; the promotion of breast-feeding and child spacing; and the prevention of neonatal tetanus. Screening activities should be carried out according to history and high risk factors. The role of the TBA, her encouragement and training is described.

1.1.5.2.

Organisation of antenatal care

* **Afganistan, Ministry of Public Health (1977)** Basic health centre manual.

Contains some excellent flowcharts: screening a pregnant woman; p.203; the history of a pregnancy; p.204; prenatal examination; p.205; risk signs; p.206; prenatal treatment; p.208; antenatal problems; pp.210-212 (including differentiating between types of vaginal bleeding, with a very useful short list); anaemia during pregnancy; pp.213-214; cough or fever in pregnancy; p.215; and nutrition during pregnancy; pp.617, 618.

* **Botswana (1982)** The Ramotswa antenatal risk card and foetal growth graph.

Short description In Salubritas 6 (4) October 1982.

A 2 sided card, developed after 10 years of experimentation, which is said to be 90% accurate in detecting high risk mothers and fetuses. It requires little time to fill in and interpret, and indicates at a glance the condition of the mother and foetus at any point during the pregnancy.

Based on a scoring system so that the midwife can decide how to counsel the mother, the card includes a graph of fundal height (with a solid guideline of the expected growth pattern), and graphs of the weight and girth of the mother. Each time the mother visits, a score is calculated. The total score is entered along the bottom of the graph. Scores above 7 suggest twins or other complications such as fluid retention or high blood pressure.

A score below 3 suggests intra uterine growth retardation. This is checked by doing a "kick count". From sunrise the mother counts the first 10 kicks of the foetus and notes the approximate time of day, for example "about noon". If the tenth kick comes later and later each day, it suggests that the foetus is in danger and the mother should be referred for further assessment. "At first glance the card looks very complicated and crowded with detail, but after initial resistance, our midwives learned to use the card in three or four sessions at the clinic. Use of the card has made it possible to detect 90 percent of at-risk patients. And the card has boosted morale, as it allows midwives to detect problems on their own".

Dissevelt, A.G., Kornman, J.J.C.M., and Vogel, L.C. (1976) An antenatal record for identification of high risk cases by auxiliary midwives at rural health centres. Trop. Geogr. Med. 28: pp.251-255.

* Everett, J. (1976) Obstetric emergencies; a manual for rural health workers. 29pp.
 Illustrated list of at risk cases for referral during pregnancy and in labour. (See illustrations: pp.12,13).

Gaskin, I.M. (1977) Spiritual midwifery.
 Contains a useful prenatal record, concisely laid out to allow a detailed patient history (e.g. TB, respiratory disease, asthma, rheumatic fever, heart trouble, high blood pressure, low blood pressure, cancer, german measles, diabetes, thyroid problems, epilepsy, bladder infections, kidney disease or infections, phlebitis, ill effects from medicine, varicose veins, ulcer, hepatitis, pelvic infections, allergies, Herpes II, birth control methods, any difficulty in conceiving, any current medications). There are also suggestions for recording the patient's family history (see Fig. 1.18.) and her mother's obstetrical experience. The latter includes: any complications of pregnancy, labour or delivery; attitude towards child-birth (positive, negative, neutral); and also whether any hormones were taken during pregnancy. The record includes the usual details on previous pregnancies, problems during previous pregnancies, past births, physical examination, pelvic examination, laboratory results, and prenatal examinations.

FAMILY HISTORY:

	Patient's Father	Patient's Mother	Patient's Siblings	Paternal Relatives	Maternal Relatives	Outcome and Details
Allergies						
Cancer						
Congenital abnormality						
Diabetes (age discovered)						
Epilepsy						
High blood pressure						
Heart disease						
Kidney disease						
TB						
Twins						
Other						

Fig. 1.17.

* Ghana, Ashanti-Akim District Profile (1978) Who needs maternity care? Reprinted in Amonoo Lartson, R., Ebrahim, G.J., Lovel, H., and Ranken, J. (1984) District health care. Challenges for planning, organisation and evaluation in developing countries.

The rising need for antenatal and maternity care in a district is partly indicated by the number of births. This figure can be obtained by using the national crude death rate and the district population to calculate the district births expected.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Better maternal and child health. An illustrated manual for dais (traditional birth attendants). Symbols used include the following:

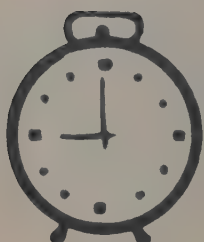
SYMBOLS USED



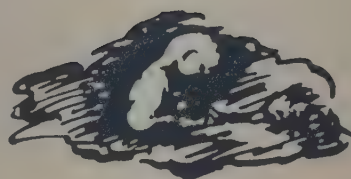
Wrong practice



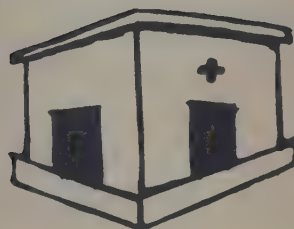
One month



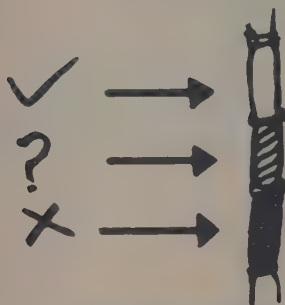
Hours



Abortion



Health Centre



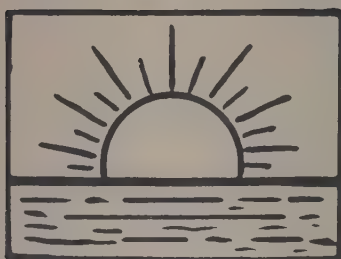
GREEN-NORMAL

yellow - at risk - special care

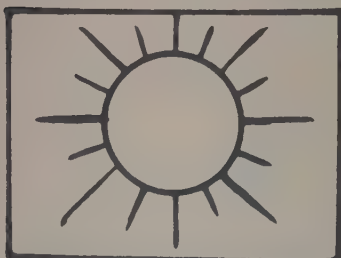
red - danger - refer



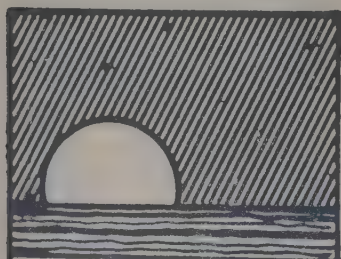
Week



Morning



Afternoon



Evening



Night

Fig. 1.18.

India, Vellore (1977) Patient retained antenatal card. Mimeo. This locally made antenatal record card was designed in the hope of:

- a) simplifying, and avoiding the problems of, record keeping.
- b) encouraging more women to attend antenatal clinic by shortening the waiting time which is spent in searching for records.
- c) providing guidelines for the health worker on the essentials of: history taking; physical examination; distinguishing between high and low risk pregnancies; and referring cases which are beyond her competence.
- d) enabling the health worker to follow up the pregnant women in their homes.
- e) providing a record of health workers' achievements and mistakes.
- f) evaluating the effectiveness of the health worker by constantly supervising the collection and recording of data.
- g) providing health education for the mother.
- h) providing the mother with a record of her present pregnancy and its final outcome, for future reference.

The antenatal card is folded into three and enclosed in a polythene bag to be given to the mother for 50 paise (0.06 cents) either on her first visit to the maternal child health clinic and/or on the health worker's visit to her home.

One of the special features of this card is the guidelines provided for the workers, many of whom have had only the minimum of education. The guidelines include a useful diagram of the height of the fundus of the uterus at certain periods during pregnancy. (See Fig. 1.21.)

Women's attitude to family planning is observed during the antenatal period. This gives an opportunity for the health worker to follow up the women who are willing and also to advise those who are not and to understand the reasons for their unwillingness. Use of the card is still in its early stages but it has already been found that "fewer are lost than the number of cards mislaid in an average small hospital's filing system", and that waiting time spent while staff search through their records has been reduced. "The mother who pays a nominal sum for her card is responsible for its safe keeping and the mere ownership of these cards seems to be a further incentive for improving the attendance at the clinics..."

"The antenatal card is also of considerable educational value to the patient. The simple instructions which are provided in the local language are intended to appeal to the mother who has her own beliefs, traditions and customs..."

"Besides being of help to the supervisor in detecting mistakes and correcting the health worker in the early stages of her career, it is also facilitates supervision by the higher ranking medical staff and assists the village health worker in assessing her own performance."



Fig. 1.19: Oedema illustration

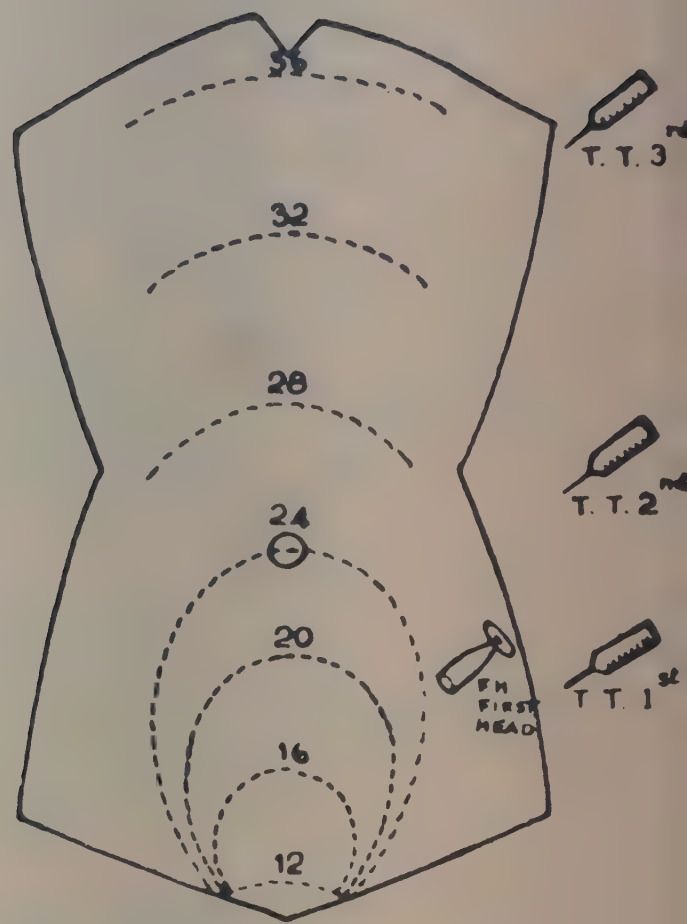


Fig. 1.20. Fundal heights and tetanus immunisations

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A and Shah, K.P. (1982) A TBA trainer's kit.

* **Management Sciences for Health** (1974) Problem action guidelines for basic health care; a tool for extending effective services through auxiliary health workers. Consists of flow charts which include: history of the pregnancy; cough or fever in pregnancy; prenatal examination; prenatal treatment; family planning. In each the chart problem presenting to a health worker leads, via history-taking and relevant examinations, to treatment or referral as well as diagnosis. Useful for reference for health workers providing antenatal care.

* **Mozambique, Ministry of Health** (no date) Antenatal record. Port. Uses one-two-and three star rating for risk factors, indicating the need for delivery at a primary health unit, or for secondary or tertiary care. The six three-star risks are: previous delivery with forceps or ventouse; previous haemorrhage; manual removal of placenta; caesarean; height less than 1.5 metres; age less than 16 years. Only women with no risk factors are suitable for home delivery.

Nadim, Nawal El Messiri (1980) Rural health care in Egypt. IDRC-TS 15e.

A research report on a study of the Dayas (traditional midwives) in rural Egypt. 94% of all deliveries in 4 villages studied were carried out by Dayas. The author gives his ideas on selection of the Dayas. They themselves think they should be chosen for good

vision, good health, intelligence, courage and a smiling face. The report also includes descriptions of local ideas on why spontaneous abortion and excessive bleeding occur.

Raleigh bicycles factory, Nottingham, UK. (no date)

Antenatal care is provided within the factory. This is a practice relevant to many places of work.

Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

Describes setting up an antenatal clinic and use of antenatal records. Includes a section on determining where the patient should be delivered.

Shah, K.P. (1978) Surveillance card for married women for better obstetric performance. The Journal of Obstetrics and Gynaecology of India 28 (6): pp.1015-1020.

* Sims, P. (1978) Antenatal card for developing countries. Tropical Doctor 8: pp.137-140.

1.1.5.3.

Evaluation of antenatal care

Coles, R.W. (no date) The training of traditional midwives and its effects on the incidence of neonatal tetanus. 4pp.

Describes the monitoring of cases of neonatal tetanus. There was a sharp fall in the numbers of such cases following the provision of antenatal care which included anti-tetanus immunisation.

Enkin, M., and Chalmers, I. (1982) Effectiveness and satisfaction in antenatal care. 297pp.

A critical reappraisal of the benefits of antenatal care. The book is divided into 3 parts. The first looks at how antenatal care developed, how it screens for disorders, and how it works in practice. The second is concerned with antenatal treatment and the impact of antenatal education. The final section looks at the challenge of antenatal care and the role of midwives, general practitioners and hospital specialists.

1.2.

Delivery care

1.2.1.

Ensuring aseptic delivery

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.

Includes illustrations of a midwife's bag and its contents: p.24. Gives illustrated instructions on p.29 for cleaning the supplies before packing the midwife bag. "Wash and boil cap, gown, mask, bag and gown wrapper. Hang up to dry, outside in air if possible. Iron with a very hot iron. Wash hands. Wrap gown in clean wrapper. Bake paper package in oven as long as it takes to bake bread. Wash hands well then pack the bag with clean supplies..."

..... The Midwife's Supplies (cont.)

Cleaning the Supplies Before Packing Midwife Bag



Wash and boil cap, gown, mask, bag, and gown wrapper.



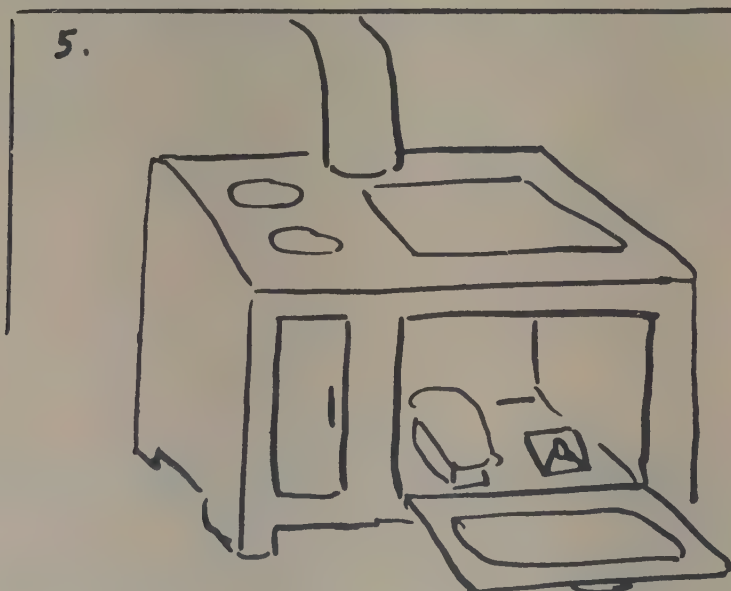
Hang up to dry, outside in sun if possible.



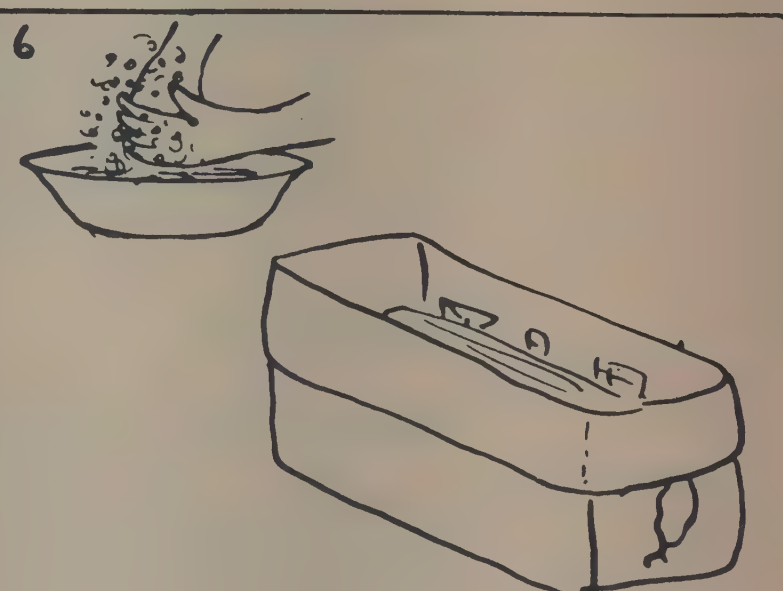
Iron with a very hot iron.



Wash hands.
Wrap gown in clean wrapper



Bake paper package in oven as long as it takes to bake bread.



Wash hands well, then pack the bag with clean supplies.

Fig. 1.21.

"The mother needs to have these things ready for herself... 2 nightgowns, cotton stockings, pillow cases, sheets, blankets, bag of clean rags, stack of newspapers and newspaper pads with instructions on how to make them from a piece of muslin folded over and stitched to the newspaper....": p.31. (illustrated).

Making the Newspaper Pads

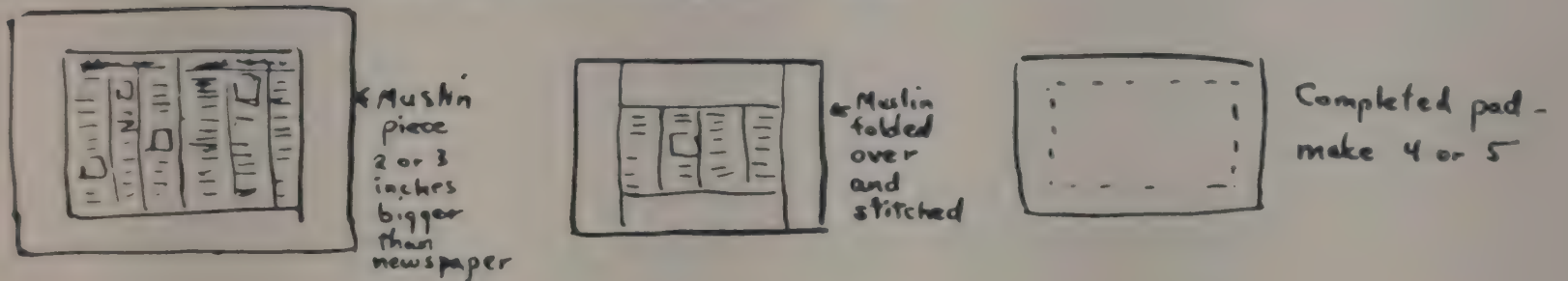


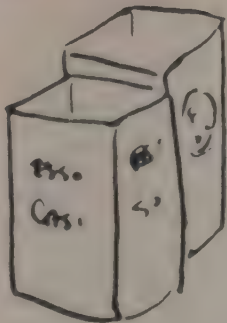
Fig. 1.22.

A list of things the mother needs to have ready for the baby is illustrated: p.32.

Finally , there is a list of household items the mother will need when labour begins: 2 or more buckets or clean gas cans, a kettle, a wash tub for soaking soiled clothes, a dipper, a large covered cooking pot, several wash basins, a barrel or buckets of water, small coffee cans, and large coffee cans.

.....The Mother's Supplies (cont.)

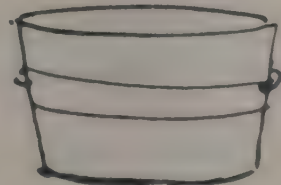
The Mother Will Need These Household Things When Labor Begins



2 or more buckets or clean gas cans.



tea kettle



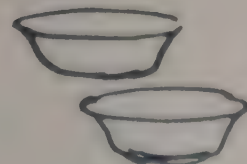
wash tub for soaking soiled clothes



a dipper



large covered cooking pot



several wash basins

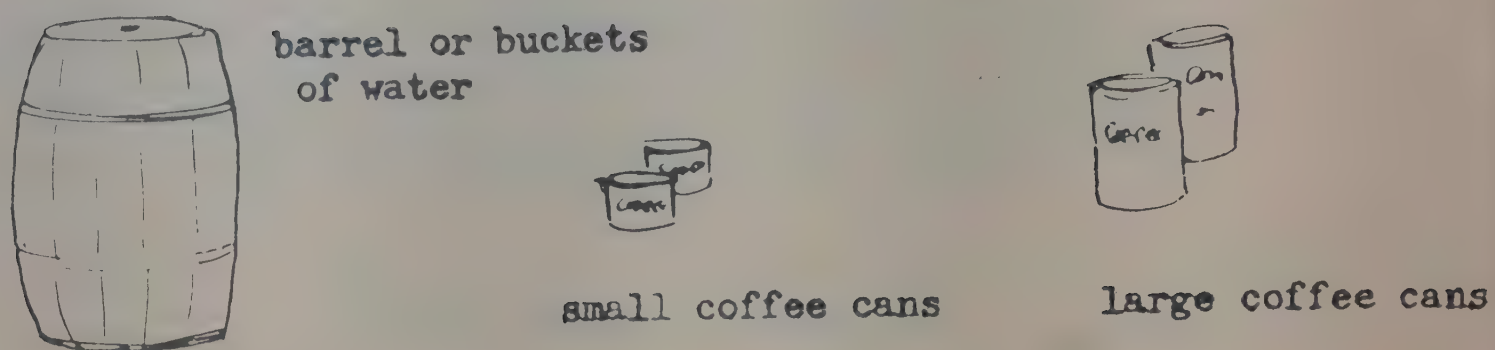


Fig. 1.23.

Byrne, M., and Bennett, F.J., (1973) Community nursing in developing countries, a manual for the auxiliary public health nurse.

Home delivery equipment is illustrated: p.54. This includes covered containers of cold boiled water, hot boiled water, a good light, and boiled string.

HOME DELIVERY EQUIPMENT

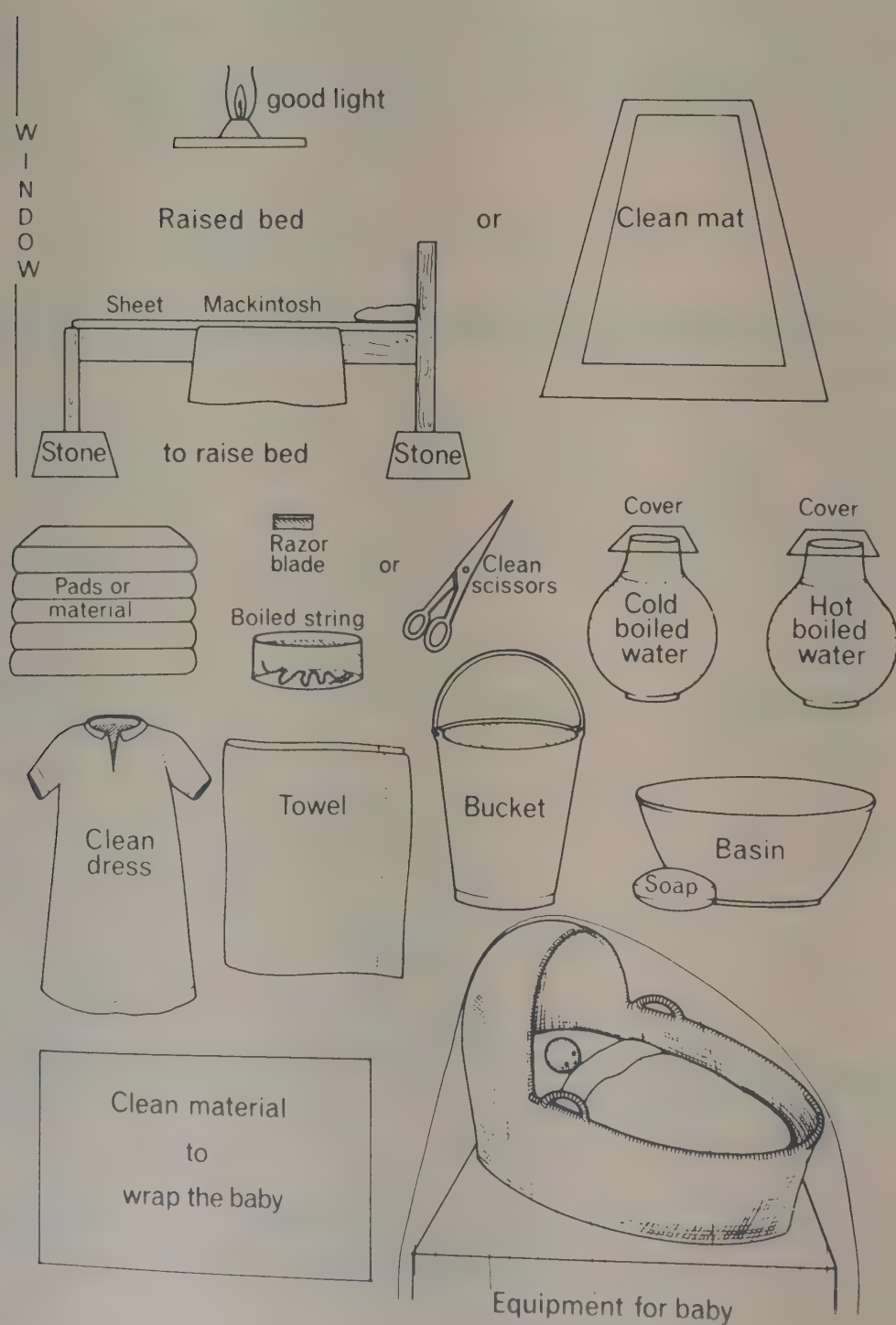


Fig. 1.24.

* Colgate, S.H. et al. (1979) The nurse and community health in Africa.

Basic contents of the traditional birth attendant's bag are listed: p.115: a bag or basket which closes securely; a measuring string with 3 knots, the first knot corresponding to the uterine height at 3 months of pregnancy, the second knot to the height at 6 months, and the 3rd knot equal to the height at the 9th month; a bar of soap; a towel or other piece of clean cloth to wipe her hands; a small stick, two or three finger-breadths long to guide her in tying the umbilical cord; something to tie the cord with (thread, raffia, etc.); a tool to cut the cord with, such as a sharp piece of bamboo, a reed, a sharp stone, a razor blade, a pair of scissors, or a knife; strips of bandage and compresses (made by the traditional birth attendant herself or purchased) tied up in a clean cloth after being boiled, dried and ironed; a torch or paraffin lamp and a box of matches; a notebook or register; eye medication; drugs to facilitate delivery or placental expulsion; a bottle of alcohol or mercurochrome.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit.

"Sterilisation of equipment."

Wherever possible, each TBA should be provided with a pre-sterilised delivery pack. The minimum requirements are that it should consist of:

- . a new razor blade
- . 4-5 cord ties
- . gauze pieces
- . cotton swabs
- . antiseptic solution in a small bottle

Until adequate supplies of such packs become available, it must be remembered that boiling is the only method of sterilisation readily available to the TBA.

Shortage of water is a fact of life in many areas, but its use in delivery should receive high priority. Where it really is not available then alternatives have to be used. Flaming, if done correctly, can be an effective method of sterilisation. Boiling in 2% soda can within 5 minutes sterilise any instrument, (R.A. Hughes, Sterilisation of instruments in isolated hospitals, Tropical Doctor (1982) 12: p.87) but the use of antiseptics such as Dettol or Savlon is not as safe as boiling.

How to teach the sterilisation of equipment.

Five main points have to be taught in relation to the technique of sterilisation by boiling:

1. Everything to be used for the actual delivery must be boiled just before the delivery, i.e. swabs, cord ties, cord cutter, bowls etc.
2. All materials must be as clean as possible before boiling.

3. Everything to be boiled must be completely covered with water.
4. The water must be made to boil.
5. Boiling must continue for an adequate length of time as described below.

Before the trainer teaches the actual sequence of sterilisation, the TBAs should make or acquire a pair of lifters (sometimes referred to as tongs or forceps) as used locally (bamboo or metal strip). They should then practise using them to lift all the pieces of their equipment out of a pot. The diagram below shows how TBAs can be taught a boiling method of sterilisation without requiring a clock...

Illustration 17

See Lesson Plan Suggestions Session 3
Key Concepts in Training Chapter 4

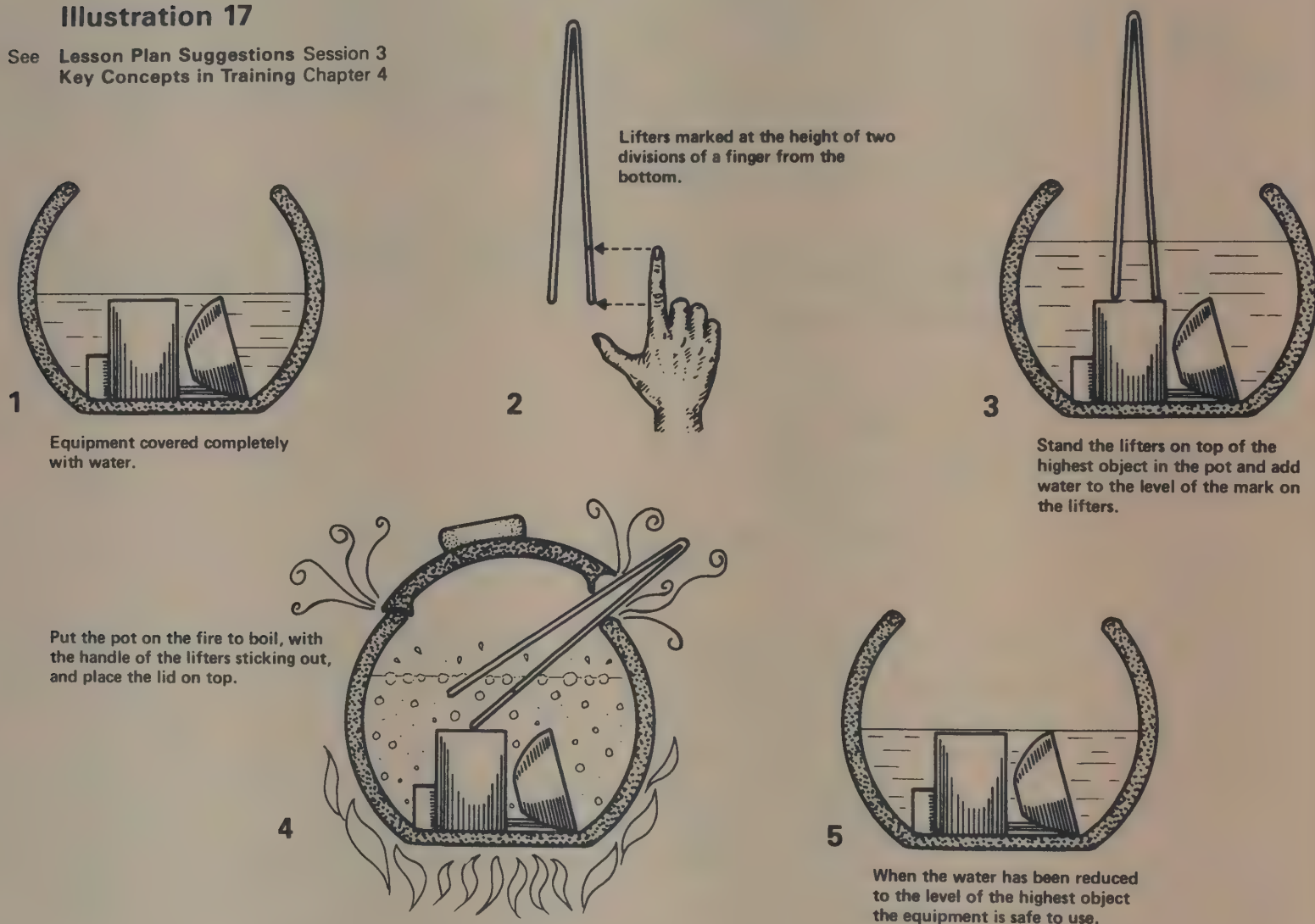


Fig. 1.25: Illustration of method of sterilisation of equipment by boiling without a clock.

Care of the hands.

One of the easiest ways of bringing about a big improvement in the TBAs' practice is to instil in them the practice of conscientious handwashing just before delivery...

At the first class the actual method of washing the hands satisfactorily for a delivery must be demonstrated step-by-step and practised by the TBAs.

Put everything to be used for the handwashing ready in a

convenient place where it is unlikely to fall onto the ground. This precaution must be linked in the TBA's mind with "soil and things which have touched soil are the greatest danger to the mother - this is why we must wash our hands so carefully". In areas where hands are washed by pouring water over them from a container (dipper), the group can practise by dividing into pairs with one person acting as the pourer. If possible one or two spectators may be enlisted, thereby spreading the idea being taught, so that those who will in future receive attendance from the TBA will demand correct practice... The demonstration will need to make clear that the special handwashing technique for delivery means 'up to the elbow'... (Local traditions for one or more long nails must be discussed and every effort made to help the TBA to feel that short clean nails are the symbol of her valued role in society. This will only be possible if the community is brought into the teaching and supports the same idea). After successful washing, the hands and forearms should be dried from the hands to the elbow, using the TBA's own towel or clean piece of material kept for the purpose. (In very hot areas, the hands and arms may be shaken dry, but the TBAs need to realise that dry hands are safer than wet)."

* Werner, D. (1977) Where there is no doctor.

Things a mother should have ready before giving birth are illustrated on p.254: "a lot of very clean rags; soap; a clean scrub brush for cleaning the hands and finger nails; alcohol for rubbing the hands after washing them; clean cotton; a new razor blade (do not unwrap until you are ready to cut the umbilical cord. If you do not have a new razor blade, have clean rust-free scissors ready. Boil them just before cutting the cord); sterile gauze or patches and ribbons should be wrapped and sealed in paper packets and then baked in an oven or ironed).

Additional supplies "for the well prepared midwife or birth attendant" are also listed, pp.254-255: "Torch, suction bulb for sucking mucus out of the baby's nose and mouth, sterile syringe and needles, several injections of ergonovine or ergometrine, two bowls (1 for washing hands, and 1 for catching and examining the afterbirth); foetal stethoscope for listening to the baby's heartbeat through the mother's belly; blunt tipped scissors for cutting the cord before the baby is all the way born (extreme emergency only); two clamps for clamping the umbilical cord or clamping bleeding veins from tears of the birth opening; sterile needle and gut thread for sewing tears in the birth opening; silver nitrate drops for the baby's eyes."

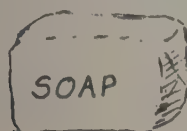
THINGS A MOTHER SHOULD HAVE READY BEFORE GIVING BIRTH

Every pregnant woman should have the following things ready by the seventh month of pregnancy:

A lot of very clean cloths or rags.



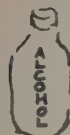
An antiseptic soap (or any soap).



A clean scrub brush for cleaning the hands and fingernails.



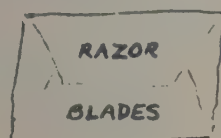
Alcohol for rubbing hands after washing them



Clean cotton.



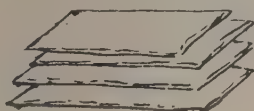
A new razor blade. (Do not unwrap until you are ready to cut the umbilical cord.)



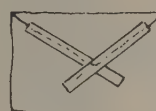
(If you do not have a new razor blade, have clean, rust-free scissors ready. Boil them just before cutting the cord.)



Sterile gauze or patches of thoroughly cleaned cloth for covering the navel.



Two ribbons or strips of clean cloth for tying the cord.



Both patches and ribbons should be wrapped and sealed in paper packets and then baked in an oven or ironed.

Additional Supplies for the Well-Prepared Midwife or Birth Attendant

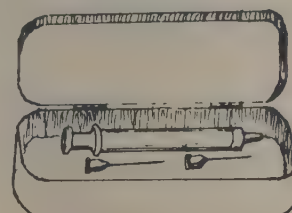
Flashlight (torch).



Suction bulb for sucking mucus out of the baby's nose and mouth.



Sterile syringe and needles.



Several injections of ergonovine (or ergometrine).



Two bowls—1 for washing hands and 1 for catching and examining the afterbirth.

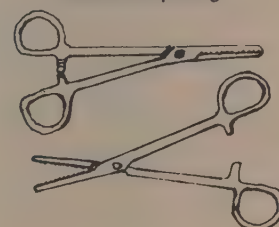


Fetoscope—or fetal stethoscope—for listening to the baby's heartbeat through the mother's belly.

Blunt-tipped scissors for cutting the cord before the baby is all the way born (extreme emergency only).



Two clamps (hemostats) for clamping the umbilical cord or clamping bleeding veins from tears of the birth opening.



Sterile needle and gut thread for sewing tears in the birth opening.



Silver nitrate drops for the baby's eyes.

Fig. 1.26.

Fig. 1.27.

1.2.2.

Monitoring labour with partograms and clocks

Bird, G.C. (1978) Cervicographic management of labour in primigravidae and multigravidae with vertex presentation. Tropical Doctor 8 (2): pp.78-84.

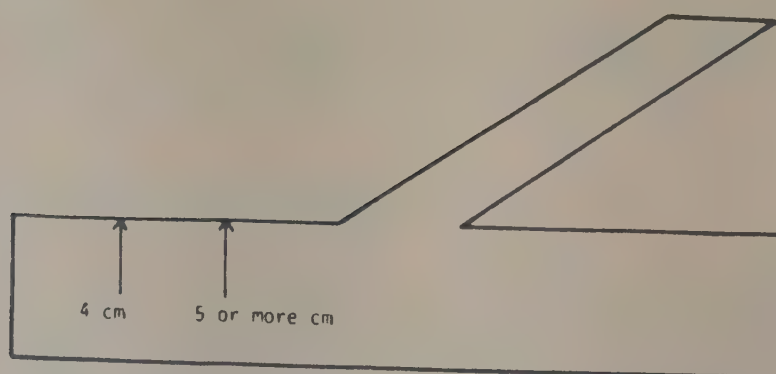


Fig. 3. Ruler for drawing Warning and Action Lines.

Fig. 1.28: Shows a ruler for drawing warning (alert) and action lines for use with a partogram.

* Gaskin, I.M. (1977) Spiritual midwifery.

* Philpott, R.H. et al (1977) Obstetrics, family planning and paediatrics; a manual of practical management for doctors and nurses.

"The composite labour graph should be used for every patient admitted to a labour ward, whether in a large hospital or small peripheral clinic. It is particularly useful in revealing problems that often go unnoticed in written notes...

The graph is meant to display all the observations made during the first stage of labour (see Figure 1.29).

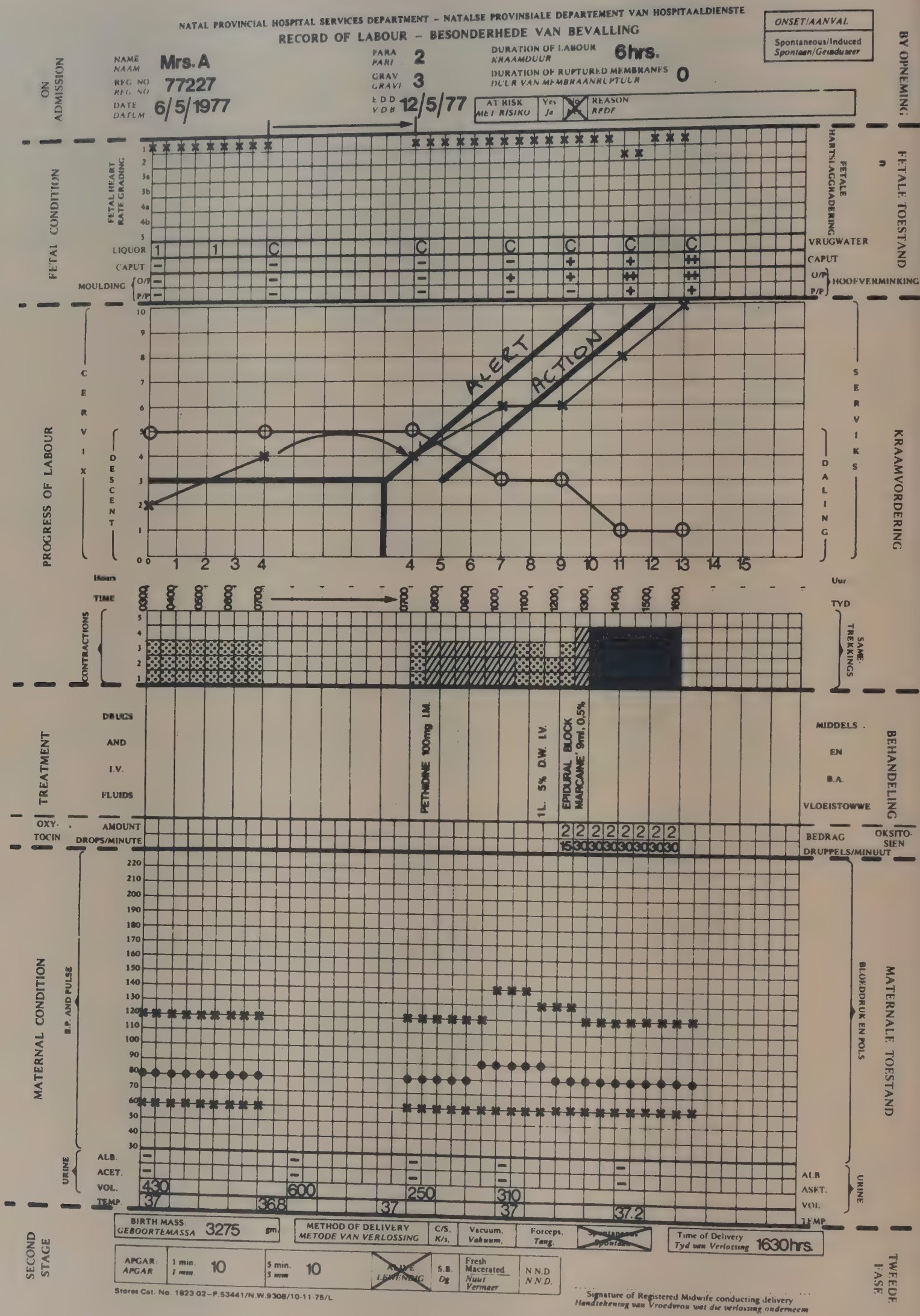


Figure 6-2 The composite labour graph

Fig. 1.29.

"The three major features recorded on the graph are:

1. Foetal condition
2. Labour progress
3. Maternal condition

Note that zero time is taken as the time of admission to hospital, rather than the problematical time of onset of labour. Both the actual time and number of hours from admission are marked off to alert the observer to the passage of time."

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

Alert and action lines of cervical dilation in relation to time are explained and illustrated; pp.55-57. Three examples are given: 1) good cervical dilation, normal labour; 2) uncertain if labour has truly begun; 3) slow dilation, action line reached, management according to parity and contraction rate and duration.

* Uganda, Makerere (Trussell) (no date). Cardboard clock to monitor progress of labour in a busy maternity ward. Cardboard clocks above each bed have been set to the time the patient was admitted so that it is clear when 12 hours of labour have elapsed.

1.2.3. Determining presentation and position

* Cox, H. (1971) Midwifery manual; a guide for auxiliary midwives. 240pp.

Tables indicate the relationship between the position of the foetal heart and the probable position of the baby.

* Gaskin, I.M. (1977) Spiritual midwifery.
p.338: determining presentation and position.

1.2.4. Management of normal labour and delivery

1.2.4.1. Signs of impending labour

* Gaskin, I.M. (1977) Spiritual midwifery.
Describes, on p.341, the signs of impending labour and how to recognise true labour.

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.
See Chapter 5.

1.2.4.2. Management of the normal first stage of labour

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.
The delivery call (pp.35-39): line drawings illustrate every action.

The Delivery Call

This Is How The Midwife Takes Care of a Mother During Labor

1.



The midwife arrives. She greets the mother and asks when labor began.

2.



She puts down her bag and takes off her parka or coat.

3.



She washes her hands in the family basin, using lots of soap.

4.



She feels the mother's abdomen during contractions to see how hard and how often they come.

5.



She sees that the fire is lit and puts water on to boil.

6.



She spreads newspaper on the table to keep her things and the table clean.

Fig. 1.30.

The illustrations continue:

"She washes her hands again. She opens her bag, takes out all the supplies and puts them on the covered table. She then puts on her midwife cap and tucks all her hair under it. She puts on her mask and washes her hands again. She arranges her supplies on the table. She closes her bag and puts it aside. She puts cotton wipes in a clean coffee can, covers with boiling water and puts on to boil 10 minutes. She puts cord scissors in pan from bag, covers with boiling water and boils 10 minutes. If mother has not already bathed, place pan of warm water, soap, wash cloth and towels near her bed. Help her if she needs help. Empty, wash and rinse basin. Scald. Rinse soap and soap dish. Make bed for delivery. Cover mattress with newspapers. Make bed with clean sheets, put newspaper pad in place. Place blanket or quilt at the side. Place newspapers on floor beside bed. Set one bottle of boiled water aside to cool. Place package of cord supplies and clean midwife gown on table near bed. Place a receiving blanket wrapped around a jar of hot water on the table. Drain water off scissors and put on table near bed. Place can of boiled cotton wipes on table. Place a baby binder and 3 pins and 2 sanitary pads on the table. Prepare a place for scrubbing hands. Have mother empty bladder and bowels. Wash abdomen and upper legs."

Dunn, P.M. (1976) Obstetric delivery today. For better or for worse. The Lancet 1 (7963): pp.790-793.

A recent British survey of women's views on the modern management of labour recorded that "Women wanting to get into a good position for pushing were ... often not allowed to be propped up ... and commented that it was a great strain to hold their legs up while lying flat ... many found themselves trying to push 'up hill'. In my view they have every right to complain. No other animal species adopts such a disadvantageous posture during such an important and critical event".

THE LANCET, APRIL 10, 1976

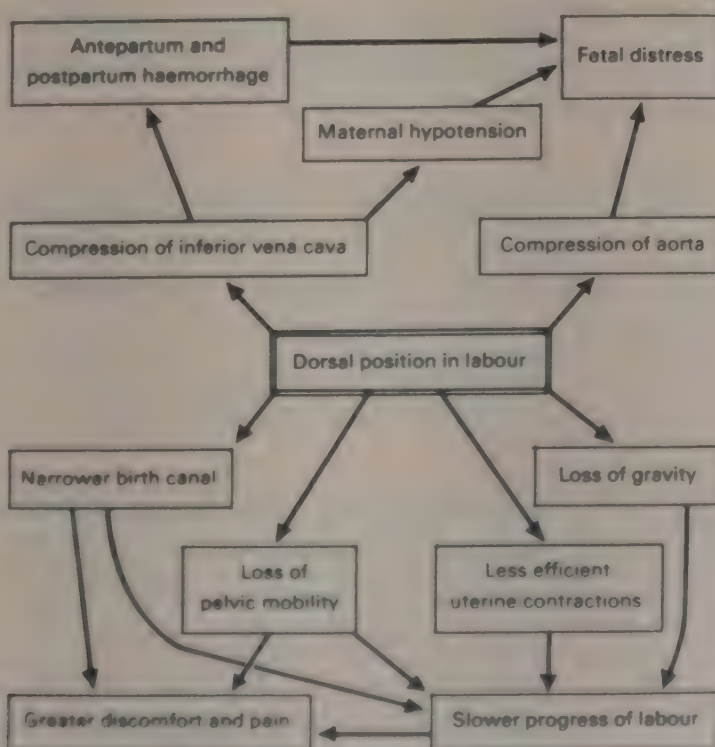
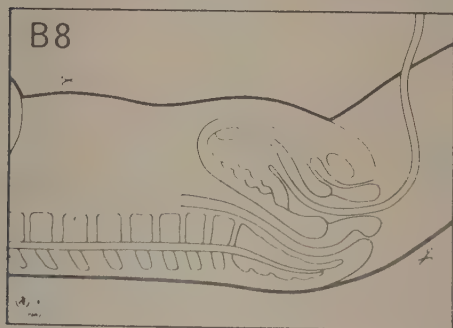
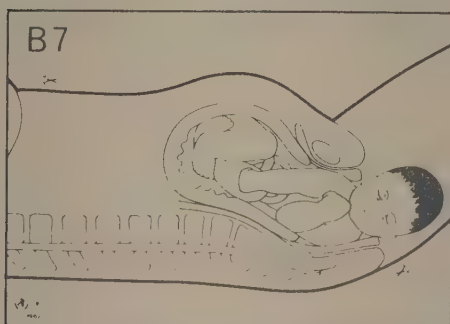
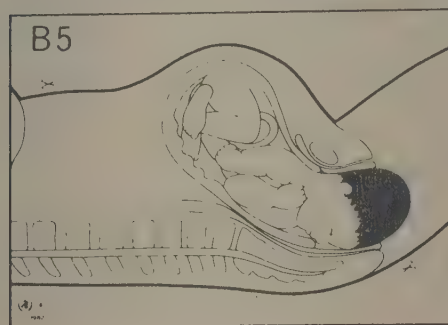
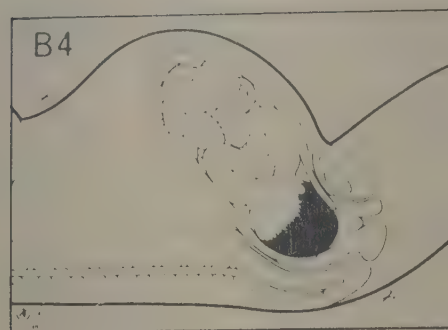


Fig. 5—Consequences of the dorsal position.

Fig. 1.31.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P.,
(1982) A TBA trainer's kit.

"Teaching the management of actual
delivery using the Ilfra doll and the
Lydia pictures."



*The reader is referred to
Teaching/Learning Resources
where the use of the Lydia
pictures in TBA training is
explained.*

Fig. 1.32.

In most sessions, one TBA should be expected to demonstrate the conduct of a simulated delivery, beginning with the preparation and sterilisation of her own equipment.

For the delivery she should be provided with an assistant,

1. Prepare and damp-wipe a floor-mat to serve as the area of delivery...
2. Instruct the TBA to prepare for delivery. It is important to stress that nothing must be pretended in relation to what the TBA will do. Experience has shown that it is safest to encourage the TBA to bring the pot of boiled equipment to the delivery area and to use the things required directly from the pot.
3. Allow the TBA to follow her own practice without comment so long as it is not actually unsafe. If it is, discuss why she acts as she does and explain why the method she has chosen is dangerous. Decide together what would be acceptable practice and why. Take the opportunity to stress non-interference and the wisdom of teaching the mother to take panting breaths during crowning, so that the head is delivered between contractions.
4. Teach the TBA to feel for a cord round the baby's neck if this is not her usual practice. From time to time, while preparing for the simulated delivery, put the cord round the doll's neck without the TBA seeing.
5. In view of the fact that TBAs have no means of 'sucking-out' the baby, the clearing of the airway by means of a piece of cloth on the finger is very important. Use an older baby if available to demonstrate the correct method of clearing the air passage".

Mendez Bauer, C., Arroyo, J., Garcia Ramos, C., Menendez, A., Lavilla, M., Izquierdo, F., Villa Elizago, I. and Zamarriego, J. (1975) Effects of standing position on spontaneous uterine contractability and other aspects of labour. J. Perinatal Medicine 3: pp.89-100.

The standing position in labour increases the intensity of contractions, diminishes their frequency, increases uterine activity but produces less pain and more comfort.

* Reid, S.E. and Mola, G. (1977) Obstetrics for health extension officers.

It is important that the following should be observed during labour: descent of the head; moulding; contractions; temperature; pulse; blood pressure; urine output; drugs; foetal heart rate. Common problems in the first stage of labour are described straight-forwardly: anaemia, dehydration, maternal distress (too much pain), full bladder, membranes ruptured for more than 24 hours, vaginal bleeding, fever. The proper management of these problems is indicated.

Scott, D.B. and Kerr, M.G. (1963) Inferior vena caval pressure in late pregnancy. J. Obstet. Gynaecol. Br. Cwlth. 70: pp.1044-1049.

Demonstrates the harmful effect of a woman lying flat on her back in the later stages of pregnancy. The enlarged uterus may partially or totally impair venous return along the vena cava resulting in hypotension and reduced blood flow to the uterus and placenta.

* WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.
Section 25: Labour.

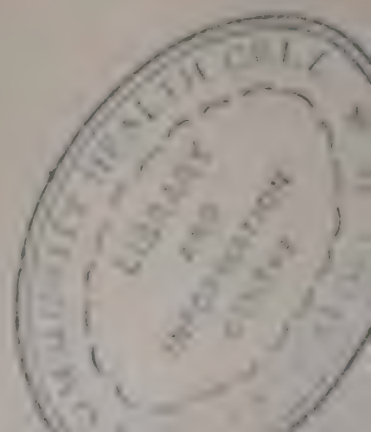
* Zaire, Bureau d'etudes et du recherches pour la promotion de la sante, (1976). Maternite et sante; notions d'obstetrique. Fr. Chapters 6 and 7 cover labour and psychological support during labour. Excellent diagrams and questions at the end of each chapter are included.

1.2.4.3.

Management of the normal second stage of labour

Hoare, S. and Weig, M. (no date) Episiotomy. How to avoid unnecessary episiotomy. Notes for midwives and postnatal care of the perineum.
A Birth Centre leaflet.

Hosken, F.P., Williams, M.L. and Garrant, M.L. (1981) The universal childbirth picture book.
Contains excellent line drawings.





25. BIRTH POSITIONS OF MOTHERS

WOMEN AROUND THE WORLD GIVE BIRTH IN MANY DIFFERENT POSITIONS. IT IS EASIER TO PUSH THE BABY DOWN, RATHER THAN UP. GIVING BIRTH IS HARD WORK. USE THE POSITION THAT IS MOST COMFORTABLE FOR YOU.

Fig. 1.33: Delivery positions (illustrated from an earlier edition).

Newton, M. (1957) The effects of position on the second stage of labour. *Surgical Forum* 7: pp.517-520.

An adjustable backrest supporting women in a more upright position resulted in increased comfort, increased cooperation by the mother and greater efficiency of expulsive efforts.

* Reid, S.E. and Mola, G. (1977) *Obstetrics for health extension officers*.

The second stage of labour: p.61 ff.

Russell, J.G.B. (1969) Moulding of the pelvic outlet. *J. Obstet. Gynaec. Br. Cwlth.* 76: pp.817-820.

The cross-sectional area of the pelvic outlet may be increased by as much as 30% when women change from the supine position to a squatting position.

WHO/BLAT (1985, In press) *Facilitating teaching-learning with modules. An approach for nurse midwife teachers*. 2nd revised edition.

Section 25: Labour.

Hosken, F.P., Williams, M.L. and Garrant, M.L. (1981) The universal childbirth picture book.

Illustrations on p.30 show a woman in the sitting position which encourages early breastfeeding. Stimulation of the nipple assists in producing a good contraction of the uterus. A sitting position encourages expulsion of the placenta.



Fig. 1.34.



Fig. 1.35.

"Afterbirth - expulsion of the placenta"

A short time after the baby is born, the uterus pushes out the placenta. If it is not expelled, the abdomen may be lightly massaged to help it come out. If bleeding is heavy or continues, you need medical help."

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit. Part 1: p.27.

When the baby has been delivered, almost all TBAs wait until the placenta is out before cutting or tying the cord. The practice of cutting the cord only after placental separation is most effective in safeguarding the mother from ascending infection and should not be changed, except: in the case of an asphyxiated baby or when a placenta is slow in separating.

1.2.4.4. Management of the normal third stage of labour

* Gaskin, I.M. (1977) Spiritual midwifery.

p.367: "The (physiological) separation of the placenta from the uterine wall usually happens within five minutes after the baby's birth. The uterus gets smaller as it contracts and the placenta stays the same size. It eventually buckles and .. separates. Usually there is a small gush of dark red blood (about two to four tablespoons) from the mother when the placenta separates. The placenta will usually come out shortly after this ..."

"After the placenta has separated from the uterus wall, the contractions of the uterus push the placenta out through the cervix. It is then pushed the rest of the way out by the mother

pushing with her belly muscles ..."

"You will need to pay special attention to delivering the placenta without breaking off any of the membranes, leaving them inside the mother. This could cause more bleeding."

Walsh, S.Z. (1968) Maternal effects of early and late clamping of the umbilical cord. The Lancet 1: pp.996-7.
Significantly greater post partum blood loss was found among women in whom the cord was clamped early (within 10 seconds of delivery of the feet) rather than later.

Werner, D. (1977) Where there is no doctor.

The delivery of the placenta (afterbirth); p.264. "Normally the placenta comes out 5 minutes to an hour after the baby is born, but sometimes it is delayed for many hours ..."

"When the afterbirth comes out, pick it up and examine it to see if it is complete. If it is torn and there seem to be pieces missing, get medical help. A piece of placenta left inside the womb can cause continued bleeding or infection ..."



Fig. 1.36.

If the placenta is delayed in coming but "the mother is not losing much blood, do nothing. Never pull on the cord. This could cause dangerous haemorrhage (heavy bleeding) ..."

"If the mother is losing blood, feel the womb (uterus) through the belly. If it is soft, do the following:

Massage the womb carefully, until it gets hard. This should make it contract and push out the placenta.



If the placenta does not come out soon, and bleeding continues, push downward on the top of the womb very carefully,



while supporting the bottom of the womb like this.

Fig. 1.37.

If the placenta still does not come out and the heavy bleeding continues try to control the bleeding and seek medical help, fast".

WHO/BLAT (1985 In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.
Section 25: Labour.

1.2.4.5. Care of the normal newborn baby immediately after delivery

* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.
Illustrates care of the newborn baby: p.60.

Cohen, S.J. et al. (1976) Newborn development.
A set of 24 slides about the developmental features of the newborn and how to determine the gestational age of the baby by assessing physical and neurological characteristics. The pre-term (less than 37 weeks), full term (37-41 weeks) and post term (after 42 weeks) gestational ages are compared in a presentation which takes the form of questions and answers. A cassette tape is also available.

Ebrahim, G.J. (1979) Care of the newborn in developing countries.
Chapter 6: Routine care of newborn.

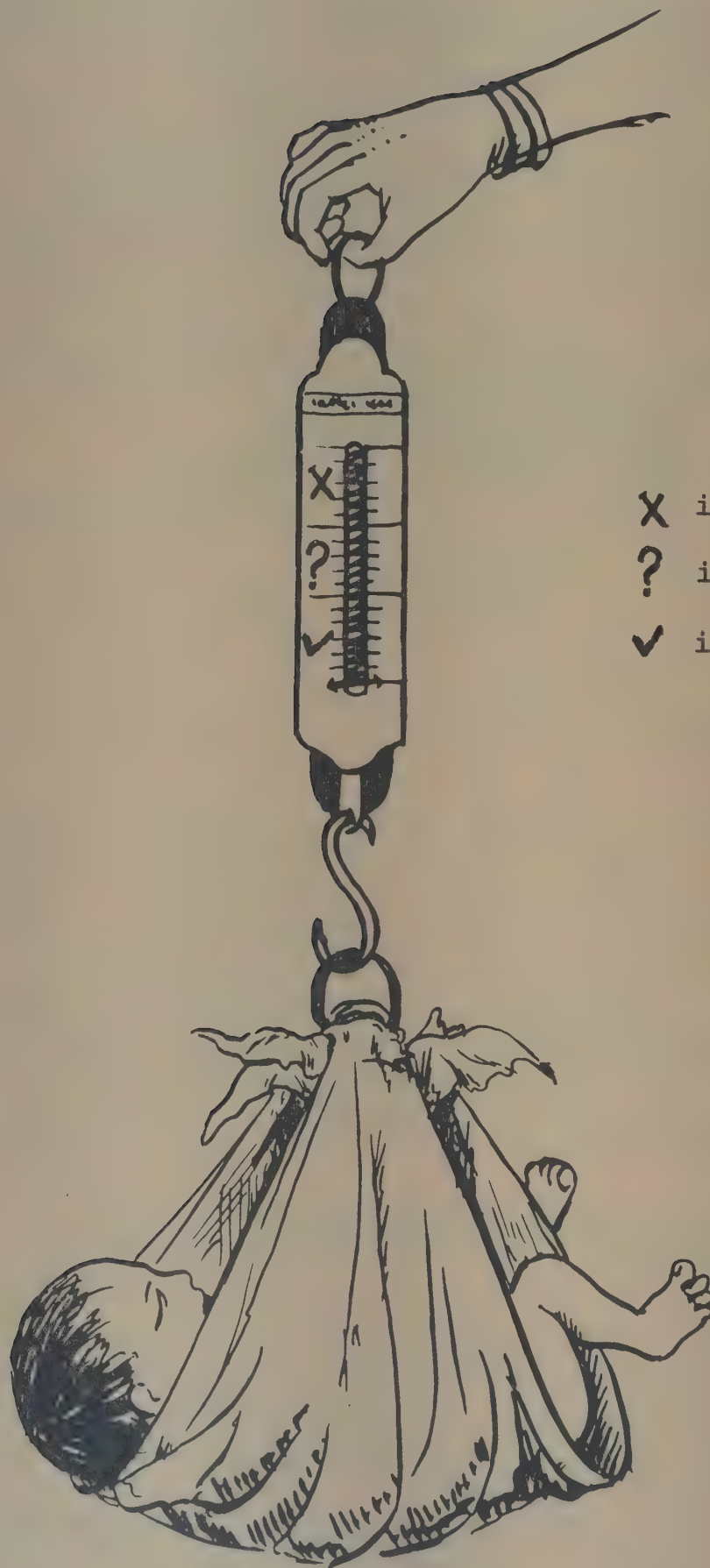
Apgar scores			
Sign	0	1	2
Heart rate	Absent	Below 100/min	Over 100/min
Respiratory effort	Absent	Slow, regular	Good cry
Muscle tone	Limp	Some flexion of extremities	Active motion
Reflex irritability	No response	Some motion	Cry
Colour	Blue or pale	Body pink, extremities blue	Completely pink

Fig. 1.38: Assessment of the newborn

* Gaskin. I.M. (1977) Spiritual midwifery.
Includes illustrated forms for use in the clinical assessment of gestational age. These are reproduced from Kempe, H. et al. (eds.) (1976) Current paediatric diagnosis and treatment. Large, 4th edition.
It is explained that in India and Ghana a simplified system of assessment, using breast nodule size and foot creases, has been applied effectively.
There is also a useful short section on birth injuries, e.g. swellings of the head, fractures, on p.437.ff. How to cope with

the referral of a baby to hospital is explained on p.389.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Better maternal and child health. An illustrated manual for dais (traditional birth attendants): p.71.



- X indicates low birthweight.
- ? indicates about 2.5. Kgs.
- ✓ indicates weight satisfactory.































Fig. 1.39.

Klaus, M.H. and Fanaroff, A.A. (1979) Care of the high risk neonate. 2nd edition.
Chapter 4: Classification of the low birth weight infant.

CLASSIFICATION OF THE LOW-BIRTH-WEIGHT INFANT

79

Neuromuscular Maturity

	0	1	2	3	4	5
Posture						
Square Window (wrist)	 90°	 60°	 45°	 30°	 0°	
Arm Recoil	 180°		 100°-180°	 90°-100°	 < 90°	
Popliteal Angle	 180°	 160°	 130°	 110°	 90°	 < 90°
Scarf Sign						
Heel to Ear						

Appars _____ 1 min _____ 5 min
Age at Exam _____ hrs
Race _____ Sex _____
B.D. _____
LMP _____
EDC _____
Gest. age by Dates _____ wks
Gest. age by Exam _____ wks
B.W. _____ gm. _____ %ile
Length _____ cm. _____ %ile
Head Circum. _____ cm. _____ %ile
Clin. Dist. None _____ Mild _____
Mod. _____ Severe _____

PHYSICAL MATURITY

Skin	gelatinous red, transparent	smooth pink, visible veins	superficial peeling &/or rash few veins	cracking pale area rare veins	parchment deep cracking no vessels	leathery cracked wrinkled
Lanugo	none	abundant	thinning	bald areas	mostly bald	
Plantar Creases	no crease	faint red marks	anterior transverse creases only	creases ant. 2/3	creases cover entire sole	
Breast	barely percept.	flat areola no bud	stippled areola 1-2 mm bud	raised areola 3-4 mm bud	full areola 5-10 mm bud	
Ear	pinna flat, stays folded	sl. curved pinna; soft with slow recoil	well-curv. pinna; soft but ready recoil	formed & firm with instant recoil	thick cartilage ear stiff	
Genitals ♂	scrotum empty no rugae		testes descend-ing, few rugae	testes down good rugae	testes pendulous deep rugae	
Genitals ♀	prominent clitoris & labia minora		majora & minora equally prominent	majora large minora small	clitoris & minora completely covered	

MATURITY RATING

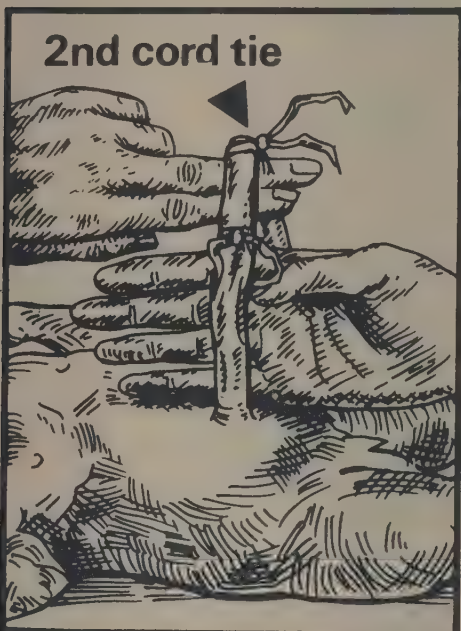
Score	Wks
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

Figure 4-6 Assessment of gestational age, University of Cincinnati. (With thanks to Dr. J. Ballard®).

Fig. 1.40.

This chapter includes several methods for assessing gestational age. The one presented involves an assessment of external physical characteristics and neurological evaluation which is then scored to give a maturity rating. This is an abbreviated version of that by Dubowitz et al. (also described).

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit.



p.28: Care of the cord.

"Advise the TBA how to treat the umbilical stump, stressing the grave risk of infection to the infant and the need to keep the stump dry. If the TBA has been provided with a delivery kit she can use tincture of iodine on a cotton swab: if iodine antiseptic or analine dye are not available, tell her to leave the stump untreated rather than risk infection with one of the traditionally used substances such as cow dung or ashes. The TBA should practise treating the stump during the simulated delivery, applying the iodine (antiseptic or analine dye) to the end of and around the umbilicus immediately after cutting, and again after the bath or clean-up, when a second stump tie has been applied behind the first, as a safeguard against leaking. N.B. Teach the TBA to boil 5 cord ties for each delivery - 3 for use and 2 in case of mishap - any cord tie that is dropped or otherwise contaminated should be burnt. The safe preparation and storage of cord ties needs discussion and practice."

Fig. 1.41: Instructions for cutting of the cord.

* Narayanan, I. and Gujral, V.V. (1981) Simplified assessment of gestational age at birth in the community. J. Indian Paediatrics 18: pp.715-720.

Criteria for assessment of gestational age are complex and usually require neurological assessment, which is disturbing to the sick infant and can be influenced by factors affecting muscle tone e.g. birth asphyxia. Fig. 1.43. below shows a simplified assesement method.

Note: First feel for the breast nodule. If it is not palpable the infant is likely to be less than 34 weeks. Assess by the lens alone. If the lens is clear or if the breast nodule is felt easily, evaluate the breast tissue, ear firmness, & plantar creases and add 4 for the lens. An alternative in the latter case (i.e. over 34 wks.), is to assess the gestational age by breast nodule and plantar creases and take the average. This method of

A simple method of assessment of gestational at birth


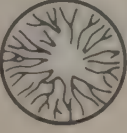
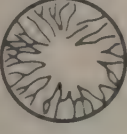

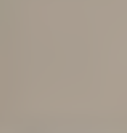


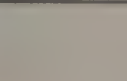




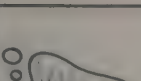
Characteristics	Relation of the total score to gestational age																								
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14										
	Weeks <27	28	29	30	31	32	33	34	35	36	37	38	39	>40											
1. Lens Vessels in the pupillary membrane seen with an ophthalmoscope set at + 20 D. (For objectiveness note diameter of clear area and relation to total diameter of lens visualised)																									
	Vessels all over the lens	Clearing < 1/4 lens diameter	Clearing = 1/4 - 1/2 lens diameter	Small loops edge Clearing 1/2 lens diameter	Lens completely clear or with occasional strand or a faint loop							Score 4													
	Score 0	Score 1	Score 2	Score 3	Score 4																				
	2 Breast nodule	Weeks <27	28	29	30	31	32	33	34	35	36	37	38	39	>40										
Size of the breast nodule (not nipple) noted by picking up between index finger and thumb	No breast tissue																								
	Score 0																								
	Breast nodule < 0.5 cm					Breast nodule - 1.0 cm					Breast nodule > 1.0 cm														
3 Ear firmness	Score 1					Score 2					Score 3														
	Some cartilage: ready recoil after folding					Firm with cartilage: instant recoil after folding					Firm with cartilage: instant recoil after folding														
	Very soft; slow recoil on folding					Firm with cartilage: ready recoil after folding					Firm with cartilage: instant recoil after folding														
Noted by palpation. Test recoil after folding of upper pinna	Score 2					Score 3					Score 4														
	Folds into bizarre shapes; no recoil					Some cartilage: ready recoil after folding					Firm with cartilage: instant recoil after folding														
	Very soft; slow recoil on folding					Firm with cartilage: ready recoil after folding					Firm with cartilage: instant recoil after folding														
4 Plantar creases Note grooves on the soles. (Fine superficial lines not so significant as they may also occur with drying and intrauterine growth retardation)	Score 0					Score 1					Score 2					Score 3					Score 4				
	No creases					Very faint lines anterior 1/2					Red marks over anterior 1/2 and grooves over anterior 1/2					Grooves over more than anterior 1/3					Extensive creases with deep grooves over anterior 1/3				
																									

Fig. 1.42.

"Ayahs" with limited education are taught to identify the premature and/or growth retarded infant by nipple size only, using a simple scale made of old x-ray film, or by comparison with the size of a split channa dal (lentil). These ayahs are taught that infants with a breast nodule of 0.5 cms or less are probably less than 34 weeks in gestational age and should therefore be assessed by a more trained person.

Local scale for measuring nipple size made of old X-ray film



Hole of diameter 0.5cm



Two marks 0.5cm apart

Where the breast nodule is palpable but is 0.5cm or less the presence of growth retardation can be identified by examining the SOLE CREASES



Grooves over more than the anterior $\frac{1}{3} - \frac{1}{2}$

Infant mature with intrauterine growth retardation



Grooves within the anterior $\frac{1}{3}$

Infant premature

Fig. 1.43.

Patient Care Publications (1979) Patient care flow chart: Managing the newborn.

* Salter Baby Weighing Scale (?1980) Distributed by CMS Weighing Equipment Ltd.

This is a Spring Balance, approx. 8" (292mm) long. It can weigh up to 10kg and has markings every 100gm. Weighing only 200gms it

is both portable and robust in its rust proof metal case. It is excellent for birth weight measurement and monitoring baby growth during the first year of life and longer.

* Werner, D. (1977) Where there is no doctor.

Care of the baby at birth: "Immediately after the baby comes out; put his head down so that the mucus comes out of his mouth and throat. Keep it this way until he begins to breathe. Keep the baby below the level of the mother until the cord is tied. (This way, the baby gets more blood and will be stronger.) If the baby does not begin to breathe right away, rub his back with a towel or a cloth. If he still does not breathe, clean the mucus out of his nose and mouth with a suction bulb or a clean cloth wrapped around your finger. If the baby has not begun to breathe within one minute after birth, start mouth-to-mouth breathing at once.

Wrap the baby in a clean cloth. It is very important not to let him get cold, especially if he is premature (born too early).

How to cut the cord: When the child is born, the cord pulses and is fat and blue. Wait. After a while, the cord becomes thin and white. It stops pulsing. Now tie it in 2 places with very clean, dry strips of cloth, string or ribbon. These should have been recently ironed or heated in an oven. Cut between the ties, like this. (Fig. 1.46.) Important: Cut the cord with a clean, unused razor blade. Before unwrapping the blade, wash your hands very well. If you do not have a new razor blade, use freshly boiled scissors. Always cut the cord close to the body of the newborn baby. Leave only about 2cms attached to the baby. These precautions help prevent tetanus."



Fig. 1.44: Holding the baby.

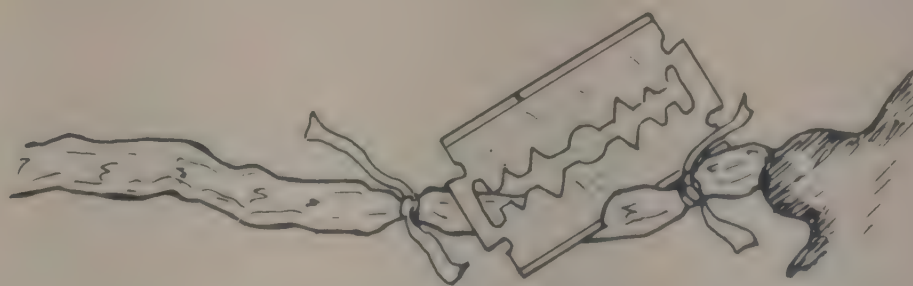


Fig. 1.45.

Care of the cut cord: (p.262) "The most important way to protect the freshly cut cord from infection is to keep it dry. To help it dry out, the air must get to it. If the home is very clean and there are no flies, leave the cut cord uncovered and open to the air..."

"If there are dust and flies, cover the cord lightly. It is best to use sterile gauze. Cut it with boiled scissors. Put it on like this:

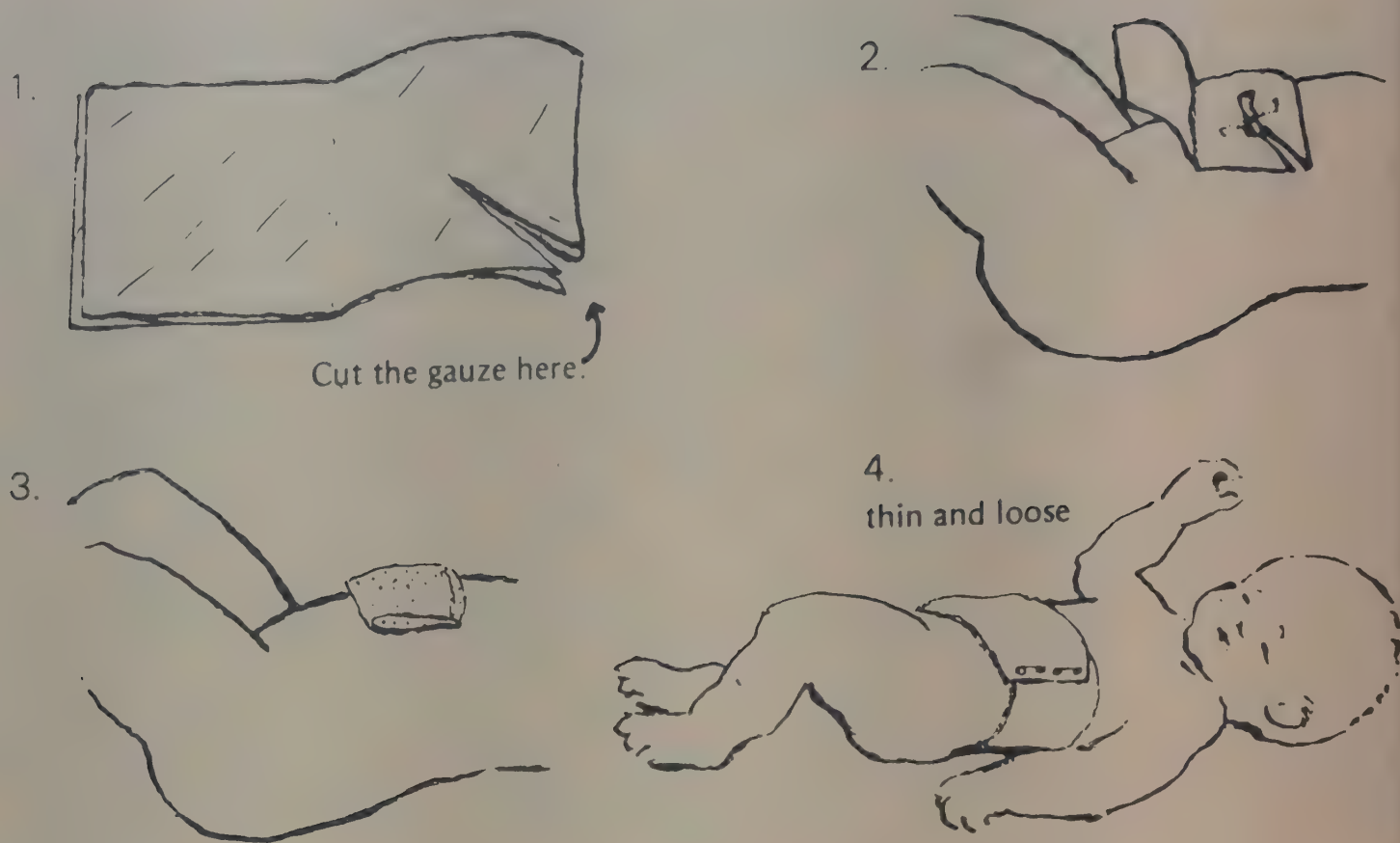


Fig. 1.46.

The drier the cord is, the sooner it will fall off and the navel will heal. For this reason, it is better not to use a belly band, or if one is used, to keep it very loose..."

Care of the newborn: "To protect a newborn baby's eyes from dangerous conjunctivitis, put a drop of 1% silver nitrate, or a little tetracycline eye ointment, in each eye as soon as he is born (p.221). This is especially important if either parent has ever had signs of gonorrhea..."

"Keep the baby warm - but not too warm: protect the baby from cold, but also from too much heat. Dress him as warmly as you feel like dressing yourself..."

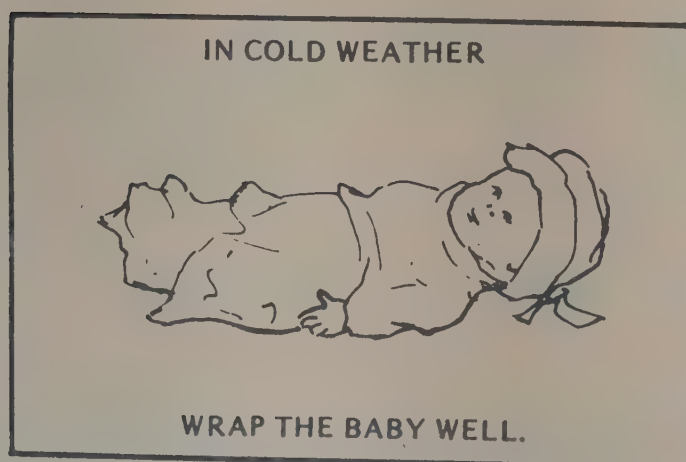


Fig. 1.47. "To keep a baby just warm enough, keep him close to his mother's body..."

Cleanliness: "Take special care with the following: Change the baby's diapers (nappy) or bedding each time he wets or dirties them. If the skin gets red, change the diaper more often - or better, leave it off! After the cord drops off, bathe the baby daily with mild soap and warm water. If there are flies or mosquitos, cover the baby's crib with mosquito netting or a thin cloth. Persons with open sores, colds, sore throat, tuberculosis or other infectious diseases should not touch or go near the baby. Keep the baby in a clean place away from smoke and dust."

WHO/BLAT (1985 In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Section 27: Immediate care of the newborn.

Zaire, Bureau d'etudes et de recherches pour la promotion de la sante. (1976) Maternite et sante; notions d'obstetrique. Fr. Chapter 8: Care of the newborn. Describes the routine care of the neonate and use of the APGAR score. Also covers problems such as: neonatal gonococcus; cord ligature, incision and management; anti-tetanus vaccination; malarial prophylaxis; BCG etc.

1.2.4.6.

Care of the normal mother postpartum

Alaska, Dept. Health and Welfare. Midwifery teaching guide for public health nurses.

The illustrated instructions continue, covering care of the mother after delivery; p.55. "The mother should do these things to help her keep well ... change sanitary pads at least 4 times a day; eat 3 good meals every day, rest lying down twice a day, bathe often". Some discomforts of the postpartum period are recognised and illustrated, e.g. afterpains; breasts that are hard and very full; and sore, cracked nipples; p.57.

Patient Care Publications (1979) Patient care flow chart: Postpartum care of the mother.

* **Werner, D.** (1977) Where there is no doctor.

The mother's health after childbirth (p.276): Diet and cleanliness are emphasised ... "During the days and weeks following childbirth the mother should eat nutritious foods (illustrated) and bathe regularly (also illustrated)." The signs and treatment of childbirth fever are explained, and instructions are given for coping with sore nipples - prevention and treatment - and breast abscess.

1.2.5.

Management of abnormal labour and delivery

1.2.5.1.

General sources on problems with delivery

Essex, B.J. (1978) Management of obstetric emergencies in a health centre.

Useful flow charts on the management of emergency situations such as severe anaemia in pregnancy, antepartum haemorrhage, breech delivery, cord prolapse, prolonged labour, eclampsia and

preclampsia, foetal distress. The book is designed "mainly for midwives".

* **Everett, J.** (1976) *Obstetric emergencies: a manual for rural health workers.* 29pp.

A practical guide as to what to do in emergencies. It explains their causes as well as the action to take. Well illustrated with line drawings.

Myles, M.F. (1975) *Textbook for midwives - with modern concepts of obstetric and neonatal care.* 8th edition. 796pp. Includes emergency operative procedures such as the application of forceps, vacuum extraction, internal version, and embryotomy; and explains how to cope with obstetric emergencies and complications during the puerperium.

Philpott, R.H. et al. (1977) *Obstetrics, family planning and paediatrics: a manual of practical management for doctors and nurses.*

This is a good practical text which includes diagnosis and management of obstetric problems and emergencies.

Van der Does, C.D., Haspels, A.A. and Lambers, M.D.A. (1984) *Obstetrics and gynaecology in basic health services.* A brief handbook on management of problems. Few diagrams.

WHO/BLAT. (1985. In press) *Facilitating learning-teaching with modules. An approach for nurse midwife teachers.* 2nd revised edition.

Includes sections on abnormal labour, different presentations, etc.

Zaire, Bureau d'etudes et de Recherches pour la promotion de la sante. (1976) *Maternite et sante; notions d'obstetrique.* Fr. Chapters 16-19, 21, 28 deal with disease and complications of labour. These include placenta praevia, cephalopelvic disproportion, "large" infant - (hydrocephalic), and breech presentation.

1.2.5.2.

Problems in the first stage of labour: prolapsed cord

Cox, H. (1971) *Midwifery manual; a guide for auxilliary midwives.* 240pp.

Explains the seriousness of a prolapsed cord. If the cord is "nipped between the presenting part and the outlet, the oxygen supply to the baby will be cut off". Recognition: the cord may be seen outside, or felt in the vagina. The foetal heart may be slower due to compression of the cord.

* **Gaskin, I.M.** (1977) *Spiritual midwifery.* Includes prolapse of the umbilical cord: p.432. "The cord is prolapsed when it drops through the cervix before the presenting part, after the membranes have ruptured. "It is suggested that a check for a prolapsed cord should be made when the water bag breaks or if the baby's heartbeat is irregular. A prolapse is usually discovered by vaginal examination. Recommended management: "If the cord is still pulsating, you can assume that

the baby is in good condition. You want to keep the baby in good condition and deliver the mother as soon as possible.

1. Have the mother get into knee-chest position as soon as possible.
2. Put your hand, with a long sterile glove on, into the mother's birth canal and push up on the baby's head (or bottom) during the contractions. The idea is to keep the head far enough up to keep it from compressing the cord during the contractions.
3. If the cord is outside the mother keep it warm and protected with a warm, damp, sterile cloth so that the blood vessels don't go into a spasm.
4. Give the mother oxygen if possible.
5. Get her to a hospital as quickly as possible..."

If prolapse of the cord happens in the first stage of labour, a caesarean section is necessary unless the doctor can quickly replace the cord. If prolapse happens in the second stage, the baby can be delivered quickly by forceps, or if the baby moves down right away, it can be delivered quickly with or without episiotomy".

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Section 24: Cord presentation and prolapse.

1.2.5.3. Problems in the second stage of labour

1.2.5.3.i. Breech delivery

* Gaskin, I.M. (1977) Spiritual midwifery.

The management of breech labour and delivery are described on p.401 ff., with good illustrations.

* Werner, D. (1977) Where there is no doctor.

Breech delivery: p.268.

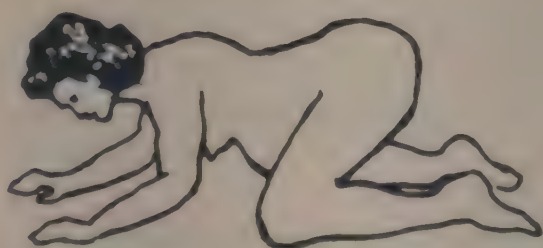


Fig. 1.48: A breech birth may be easier in this position.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Section 23: Breech presentation.

1.2.5.3.ii. Delivering the second twin

Everett, J. (1981) Twin pregnancy and labour.
A set of 24 slides and text. A cassette tape is also available.

Werner, D. (1977) Where there is no doctor.

1.2.5.3.iii. Faeces in the baby's nose and mouth

* Werner, D. (1977) Where there is no doctor: p.268.

"When the waters break, if you see they contain the baby's first black stools (meconium), the baby may be in danger. If he breathes any of the faeces into his lungs, he may die. As soon as his head is out, tell the mother to push, but to take short, rapid breaths. Before the baby starts breathing, take time to suck the faeces out of his nose and mouth with a suction bulb. Even if he starts breathing right away, keep sucking until you get all the faeces out".

1.2.5.3.iv. Cord wrapped around the baby's neck

* Werner, D. (1977) Where there is no doctor: p.268.

"Sometimes the cord is wrapped around the baby's neck so tightly he cannot come out all the way. Try to slip the loop of cord from around the baby's neck. If you cannot do this, you may have to clamp or tie and cut the cord. Use boiled blunt-tipped scissors".

1.2.5.3.v. Need for symphysiotomy

Ajayi, V. (1980) A textbook of midwifery.

The early diagnosis and prevention of obstructed labour at the district level are explained in Chapter 7. Chapter 8: Obstetric operations, covers symphysiotomy on pp.135-137. In areas where vaginal delivery and where obstructed and prolapsed labour due to cephalopelvic disproportion is common, symphysiotomy - incision into the symphysis pubis - is an alternative to caesarean section. The preparations for the operation and the tasks of the midwife are well explained. This procedure is also useful in situations where caesarean section carries considerable risk (because of lack of experienced staff, shortage of equipment, uncertainty of availability of blood, etc.)

* Van der Does, C.D., Haspels, A.A. and Lambers, M.D.A. (1984) Obstetrics and gynaecology in basic health services.

A concise illustrated handbook which covers: antenatal care; anaemia in pregnancy; labour and problems encountered around childbirth; management of labour, including symphysiotomy and caesarean section; family planning; abortion; infections and management during pregnancy.

1.2.5.3.vi. Episiotomy

* Kitzinger, S. (ed.) (1981) Episiotomy: Physical and emotional aspects.

A group of experienced obstetricians and midwives argue that

episiotomy has virtually no scientific basis and yet it has been widely used in some countries (30-70% of all deliveries). In the West it is the only operation done on mothers without their consent. One person is said to have heard this remark: "I heard the midwife say to the student that an episiotomy might not be necessary but she would do it anyway to show him (the student) how".

The technique of episiotomy is shown and its emotional consequences are discussed. It is a trauma (surgical) from which mothers have to recover and may have wide effects including dyspareuria for a considerable time thereafter.

"Episiotomy and suturing of the perineum can be traumatic for the mother, and for many women the postpartum experience is marred by severe perineal discomfort. Some say that episiotomy and suturing of the perineum was more painful than anything in labour itself and it is the thing they dread most about having another baby. Post-partum pain may interfere with the mother's early relationship with her baby and the establishing of breastfeeding". If it has to be done some argue that the midline has distinct advantages and the way that stitching is done is also very important.

The book contains extensive anatomical drawings.

Midline Versus Mediolateral Episiotomy

		Midline	Mediolateral
i.	Repair:	Easy	Difficulty increases with the size of the incision
ii.	Blood Loss:	Less	Greater
iii.	Puerperal pain:	Rare	Universal
iv	Associated Haemorrhoids:	Less	Greater
v.	Anatomical apposition:	Usually good	Commonly faulty
vi.	Dyspareunia and scar tenderness:	Rare	Not uncommon
vii.	Third degree extension:	Not uncommon	Rare

Table 1.1.

Weig, M. (1982) Conservative midwifery. The case for intact perineums. In The practising midwife. Report of the 1982 National Conference of the Association of Radical Midwives, May 1982: pp.35-39.

"How to keep the perineum intact.

We have all been taught with great care how to perform an episiotomy after infiltrating with a local anaesthetic. But how many of us were taught as carefully to assist at a birth and leave the perineum intact? Active second stage begins not when we ascertain full dilation but when a woman feels the urge to push as the head descends, and put pressure on the rectal and pelvic floor

muscles. Usually the head is just slightly visible at this point. Feelings of expulsion come in waves. As the wave of the contraction comes over a woman her breathing tends to become shorter and sharper as she takes quick breaths in and out through a slightly open mouth. If you ever get the chance to see animals give birth you can see that this is what they do. So we don't teach women levels of breathing or breath holding. Instead we encourage them to relax and discover in labour what every animal instinctively knows. As the contraction increases in power the woman lifts her breathing so that it becomes lighter and more shallow. As the pushing asserts itself the breath will be held while she bears down, opening up the vagina and actively giving birth. Women don't seem to need to do heavy breathing or to have a big breath held behind a tightly closed mouth. If you try closing your mouth and clenching your jaw you'll discover that you cannot relax your vagina and perineum at the same time. Try it now. You can't do it and neither can a woman in the second stage do both. There is a connection between an open mouth and an open vagina. At the end of each contraction I try to remind her to take a couple of sighing breaths and to relax completely".

1.2.5.3.vii. Tearing of the birth opening

* Werner, D. (1977) Where there is no doctor: p.269.

"The birth opening must stretch a lot for the baby to come out. Some times it tears. Tearing is more likely if it is the mother's first baby ..."

"Tearing can usually be prevented if care is taken:



The mother should try to stop pushing when the baby's head is coming out. This gives her birth opening time to stretch. In order not to push, she should pant (take many short rapid breaths).



When the birth opening is stretching, the midwife can support it with one hand and with the other hand gently keep the head from coming too fast, like this:



It may also help to put hot compresses against the skin below the birth opening. Start when it begins to stretch..."

Fig. 1.49.

"If a tear does happen, someone who knows how should carefully sew it shut after the placenta comes out (see pp.86 and 366)."

1.2.5.3.viii. Difficulties with delivery of shoulders

Gaskin, I.M. (1977) Spiritual midwifery: p.364.

If neither of the baby's shoulders moves as the mother pushes, the mother should be encouraged to turn onto her hands and knees with

her bottom towards the midwife:

"You can then try first to deliver the top shoulder (now underneath) by gently lifting the baby's head toward the ceiling. This is a good position for delivering large-shouldered babies.

1) It seems to further relax the pelvis and 2) you have more room in which to manipulate and apply traction to the baby's head in order to help the shoulders out. Be careful not to press your fingers into the baby's neck".



Fig. 1.50: Delivering baby with large shoulders.

The risk of post-partum haemorrhage is increased in women with:

1. Previous haemorrhages.
2. Three or more children born very close together. (This risk is less if the mother has exercised her body back into good condition between pregnancies).
3. Twins or polyhydramnios. An over-stretched uterus may have trouble keeping its tone.
4. Anaemia.
5. Blood loss earlier in labour, e.g. from an abruptio placenta or placenta praevia.
6. Prolonged labour.
7. A low-lying placenta.

"If the uterus has anything extra in it, such as partly retained placenta or a retained blood clot, it can't contract down as effectively as necessary to constrict the blood vessels of the placental site".

* Werner, D. (1977) Where there is no doctor.

The correct use of oxytocics: p.266.

"There is no safe medicine for giving strength to the mother or for making the birth quieter or easier".

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Section 30: Postpartum haemorrhage.

* Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (1976) Maternite et sante; notions d'obstetrique. Fr.

- 1.2.5.4.ii Retained placenta (with little bleeding)
- * Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.

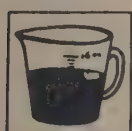
1.2.5.4. Complications of the third stage of labour

1.2.5.4.i Bleeding

Everett, J. (1976) Obstetric emergencies; a manual for rural health workers. 29pp.
Illustrated instructions of what to do for different problems.

POST-PARTUM HAEMORRHAGE

DIAGNOSIS

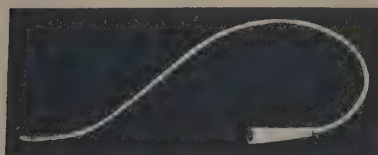
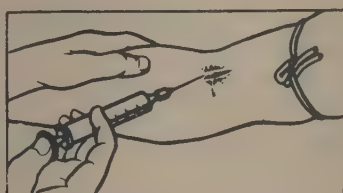


Any blood loss over 250 ml (10 ozs) should be considered abnormal and treated energetically. Remember midwives and doctors usually underestimate blood loss.

MANAGEMENT

RUB the uterine fundus to make it contract.

INJECT ergometrine 0.5 mg I/V (or syntometrine, 1 vial, I/V). Most haemorrhages will be controlled by the above measures.



CATHETERIZE (as a full bladder inhibits uterine contractions).

I.V. FLUIDS. If available, add 20 units of oxytocin (syntocinon or pitocin) to 500 ml of infusion fluid and run in at 80-100 drops.



PETHIDINE



IF THE BLEEDING IS STILL NOT CONTROLLED, SUBSEQUENT MANAGEMENT DEPENDS ON WHETHER OR NOT THE PLACENTA IS RETAINED IN THE UTERUS

24

Fig. 1.51

A. PLACENTA RETAINED



Try controlled cord traction. If this fails and bleeding continues:—

Do a P.V. and if the cervix is wide open perform manual removal of the placenta. If the

cervix is closed, making manual removal impossible—REFER to hospital with the I/V fluids running.

In all cases of manual removal strict asepsis must be practised, and the patient should be kept under observation in the Health Centre on antibiotics for at least 5 days post partum.



B. PLACENTA DELIVERED BUT BLEEDING CONTINUES

Palpate the fundus of the uterus. If it is well contracted bleeding is likely to be from a laceration.

If fundus is SOFT:—

- Continue to rub the fundus and do bimanual compression (i.e. uterus is squeezed between the right hand in the vagina and the left hand pushing on the fundus through the abdominal wall)
- REFER immediately. It is essential a trained nurse accompanies the patient as fundal massage or even bimanual compression may be necessary during the journey.



If fundus is HARD:—

- Inspect vagina and perineum for bleeding lacerations and, if possible, suture. If no obvious laceration seen—
- Insert a vaginal pack and REFER. (Do not waste time looking for upper vaginal and cervical lacerations which are not suitable to suture in a Health Centre.)

25

Fig. 1.52

* Gaskin, I.M. (1977) Spiritual midwifery.

Covers postpartum haemorrhage and its treatment: p.434.

"By definition, postpartum haemorrhage is the loss of at least 500 ml of blood during and after the birth of the baby. 500 ml is about 2 cups. Remember that a little bit of blood can look like a lot. You can best tell how severe a haemorrhage is by its effect on the mother. Postpartum haemorrhage most often happens after the birth of the baby before the placenta comes out or directly after it comes out, but it can happen any time during the first day..."

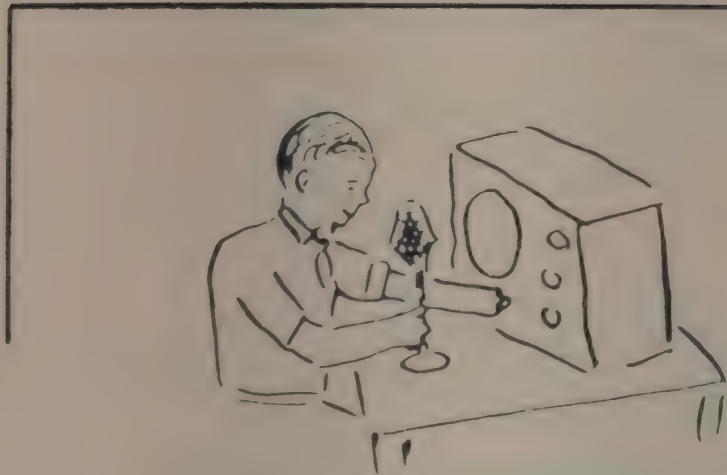
.....Danger Signs During Delivery (cont.)

If the Afterbirth Does Not Deliver



If there is little or no bleeding

Do These Things



Notify the doctor or nurse.



Have mother empty her bladder.



Let mother rest. Do nothing else. It does not do the mother any harm to have the placenta stay for many hours if there is little or no bleeding.

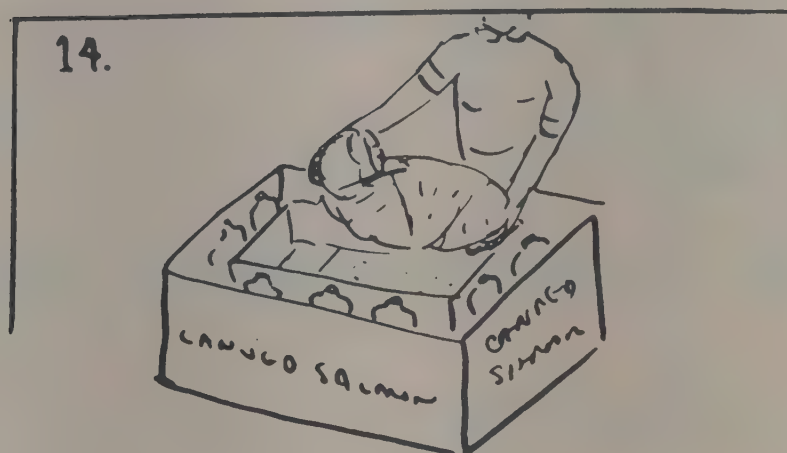
Fig. 1.53.

1.2.5.5.

Problems in the newborn baby

* **Ajayi, V.** (1980) A textbook of midwifery.
Chapter 11: Diseases and abnormalities of the newborn. The 'floppy' baby, causes and management: a well written account of this condition.

* **Alaska, Dept. Health and Welfare** (1966) Midwifery teaching guide for public health nurses.
Care of the premature baby, especially keeping it warm in a double box with hot water bottles between the two walls.



Place the baby gently in the bed.

Fig. 1.54.

Cox, H. (1971) Midwifery manual; a guide for auxiliary midwives. 240pp.

Shows a premature baby cot made from cloth with pockets for hot water bottles: p.133.

* **Cross, A.W.** (no date) Care of the newborn in Kenya. 50pp.

Written for health workers in a hospital setting. Chapter 2 on resuscitation is particularly useful.

* **Ebrahim, G.J.** (1980) Practical mother and child health in developing countries.

Section (iv) of the book is devoted to resuscitation of the newborn. The basic techniques are explained.

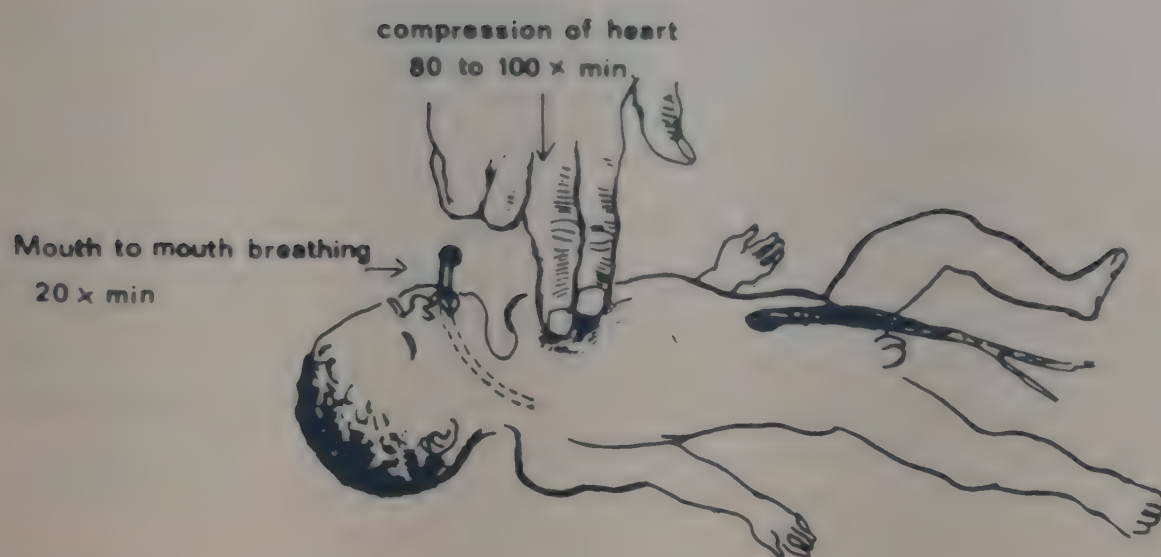


Fig. 1.55: Technique of resuscitation

* Laurance, B. (1979) Newborn care.

A set of 24 slides with script. A cassette tape is also available. It is designed to help nurses, midwives and auxiliaries with the care of newborn infants.

Includes "first aid" management of: failure to start breathing (asphyxia); engorged breasts; and jaundice. Slides 1-4 show the first few moments after birth; slides 5-8 deal with the cord; slides 9-12 show the baby's temperature and position; slides 13-16 cover infection and weighing; slides 17-18 deal with jaundice; slides 19-21 explain resuscitation; slides 22-24 show feeding and bathing.

* Werner, D. (1977) Where there is no doctor.

Problems the baby is born with.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Sections include items on neonatal infections, neonatal tetanus, etc.

Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (1976) Maternite et sante; notions d'obstetrique. Fr. Chapters 28 and 29 deal with traumatic lesions of the newborn (birth injuries, internal and external), and diseases of the newborn (infections, anaemias, haemorrhages, pre-term babies, congenital malformations).

1.2.6. Planning, organisation and evaluation of delivery care

1.2.6.1. Planning of delivery care

* Bayoumi, A. (1976) The training and activity of village midwives in the Sudan. Tropical Doctor. 6: pp.118-125. Traces the history of their work in the Sudan since 1920.

* Bella, H. (1980) Sudanese part-time village health workers. IPPF Medical Bulletin, 14 (1): pp.2-4.

It is more than half a century since village midwives in the Sudan, mostly illiterate, started to provide health care for mothers during childbirth. They differ from other TBAs in that they receive formal training from the beginning, they are registered and have legal recognition. Every year about 350 village midwives graduate from several schools all over the Sudan. The author believes that nearly two-thirds of all deliveries in the Sudan are now carried out by the village midwives. The result has been a drop in maternal mortality in hospitals, in emotional stress, and in expenditure of government resources.

* Colgate, S.H. et al (1979) The nurse and community health in Africa.

Chapter 4, Section IV: Delivery care. Describes TBA activities before, during and after delivery. Central to TBA training is the need for TBAs to be able to recognise, antenatally, women who will be a high risk; to recognise the onset, duration and severity of labour; and to understand the proper care of the newborn, including care of the cord and the promotion of breastfeeding. The TBAs should use a delivery kit to ensure aseptic delivery. The author recommends story telling, which is characteristic of West Africa, as a method of teaching.

Du Gas, B., Mangay Maglacas A., Pizurki, H. and Simmons, J. (1978) Traditional birth attendants. WHO Offset Publication No.44.

Deals with TBA training and the evaluation of health services with reference to TBAs. A good guide for planners of health services.

India, Miraj Medical Centre, Maharashtra (1980) Pocket sized kits for traditional birth attendants, the dai kit. Many kits for TBAs are cumbersome and difficult to use. This one is a small useful, sterilised kit which has helped reduce and almost eliminate neonatal tetanus and sepsis from the area. It contains a razor blade, 2 cord ties, 2 swab sticks, 2 pieces of gauze and a small sealed bottle of iodine (empty injection penicillin bottles are used).

* Moynahan, M. et al. (In preparation) TBA training material for India.

Uses Indian symbolism to indicate good practices (an auspicious parrot); bad practices (an owl); and dangerous practices (a snake).

* Trussel, B.R. (1966) Maternity care. In King, M. (ed.) Medical care in developing countries.

The maternity village or 'hostel' is a group of huts where expectant mothers come and spend the last days of pregnancy under the supervision of doctors or nurses. The maternity village can also be a training place for nurses and midwives.

Verdereese, M. and Turnbull, L.M. (1975) The traditional birth attendant in maternal and child health and family planning, a guide to her training and utilisation. WHO Offset Pub. No. 18. Useful for planners and teachers, this book mainly deals with the definition and objectives of traditional midwifery, the tasks that

are or could be done by the TBA, methods of knowing about traditional practices (survey), the evaluation of a programme to enable TBA participation in health care etc. The content of TBA training is described, including risk recognition.

* VHAI (1977) "Prevention of tetanus in the newborn by a sterile delivery pack. 2pp.

Emphasises that there should be a delivery pack for every pregnant woman. Describes the preparation of the low cost pack given to each woman who attends an antenatal clinic, so that she is prepared for delivery at home:

Instructions for preparing pack:

- a) take a piece of string and a razor blade, wrap in a clean cloth and autoclave;
- b) put some aqueous iodine 1% solution into a boiled or autoclaved empty penicillin bottle (vial) and seal with candle wax;
- c) put (a) and (b) into a plastic bag and seal the bag with the flame of a candle or with an electric sealing machine (available via VHAI);
- d) write the instructions for the use of the pack in the local language: i.e. (i) wash hands properly with soap, (ii) deliver the baby on to a clean sheet, towel or cloth, (iii) wash hands again and open pack, and (iv) use the string to tie the cord in two places and then use the razor blade to cut between the two knots in the cord (to prevent bleeding). This is also described at the antenatal clinic. Where mothers have learned these procedures there is no need to repeat the instructions in the pack.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Alerts planners to the fact that problems will follow when any group of people, regardless of how well intended they are, impose or force their ideas on another group of people: p.7-6.

Suggests that old customs intended to protect health can and need to be identified. The challenge for the health worker or educator is not 'to change people's behaviour'. It is to help people understand, respect, and build on what is healthy in their own culture.

Every area has unique traditions and customs that protect health. Health workers need to identify the beneficial customs in their own villages. Here are a few examples from different parts of the world.



"In Guatemala, village midwives put a hot coal against the freshly cut cord of a newborn baby. In other parts of the world, midwives press a red-hot knife against the cord. These practices kill germs and help dry out the cord, preventing tetanus."

Fig. 1.56.



"The thin sac or membrane (amnion) attached to the placenta, or after-birth, has long been used in Africa to help heal chronic wounds and ulcers. Recent studies have shown that the amnion has powerful healing properties. It is now being used in some hospitals for treatment of ulcers that don't heal".

Fig. 1.57.

Moreover, new customs can cause health problems when old customs change, for example:



Fig. 1.58

"The traditional squatting position for childbirth is usually easier for the mother, because the weight of the baby helps her to push. The modern lying-down position is easier for the doctor, but not for the mother. This is only one of the many examples of how modern medicine often puts the doctor's needs before the patient's.



Fig. 1.59

Williams, B. (1979) The traditional birth attendants. Data from Sierra Leone on how to integrate TBAs into health care, with the help of local professionals. An example for planners training TBAs in midwifery. TBAs are the most likely to be the first to arrive at obstetric emergencies in rural areas. They need training in risk recognition and management.

* WHO (1979) Traditional birth attendants - an annotated bibliography on their training, utilisation and evaluation (unpublished). HMD/NUR/79.1

Also supplement I (1981) HMD5/NUR/81.1
and supplement II (1982) HMD/NUR/82.1.

* WHO, Regional Office for South East Asia (1973). Notes for the practising midwife. A useful booklet which includes the training of dais: Chapter IV.

1.2.6.2.

Organisation of delivery care

Blum, T. (no date) Obstetrique. Fr. A low cost duplicated manual with tightly spaced words but large clear helpful diagrams. Could possibly be used as source material for teachers in French-speaking countries. It includes an

illustration bank on aspects of delivery care.

Cox, H. (1971) Midwifery manual; a guide for auxiliary midwives. 240pp.

Sample record cards for delivery.

* Ghana, University of Ghana Medical School (1977) A programme manual for traditional birth attendants, organisation, training and evaluation.

A very useful training guide. Includes examples of record forms.

Indonesia, Directorate General of Community Health (1976) Health centre reference manual, Vol. 1: Section on organisation of referral care.

Lists referral procedures from a health centre. It would need simplifying for village workers: p.1/VII/3.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit.

Pictograms: See Section 1.2.2. of this bibliography.

* Sudan (no date) Coin referral system during labour for non-literate village midwives.

Coin referral system during labour for non-literate village midwives, Sudan (1982 ?)

1. Haemorrhage



First stage



Second stage



Third stage

2. Delay in progress of labour



First stage



Second stage



Third stage

3. Doubtful presentations



First stage



Second stage



Third stage

Three colours of cardboard coin used for referral during labour, one each for haemorrhage, delay in progress of labour and doubtful presentations marked I II or III to indicate stage of labour.

Fig. 1.60.

VHAI (1977) Better child care. 48pp. Many languages and Eng. Ghanain version also available. Includes delivery care to be carried out by villagers. Useful.

* WHO, Regional Office for South-East Asia (1973) Notes for the practising midwife.

Contains useful do's and don'ts in the introduction, e.g. be cheerful. Emphasises the necessity for liaison, i.e. with the hospital, maternal and child health clinics, vaccinators, medicosocial workers, health officers, registrars, medical practitioners, special clinics, voluntary societies, community health centres, headmen, sanitary officers, traditional birth attendants, creches etc.: pp.4-7, and also the role of the midwife in community development: pp.8-11. How to teach traditional birth attendants is described on p.13.

1.2.6.3.

Evaluation of delivery care

Chard, T. and Richards, M. (eds.) (1977) Benefits and hazards of the new obstetrics.

Produced as a result of a meeting of gynaecologists, paediatricians, obstetricians, sociologists and psychologists. It covers the critical areas of controversy which have arisen over current technological innovations in obstetrics. The meeting suggested that further medicalisation in some areas might be counter productive and that resources could be developed more rationally.

* Egypt (1982) TBA reporting form.

TBAs were called in to help redesign a pictorial birth information sheet.

"Doctors, health administrators, and licensed midwives often dismiss traditional birth attendants as illiterate practitioners who prey on the superstitions of pregnant women.

In some cases, however, traditional birth attendants are recognised as providers of a valuable service, and there are attempts to integrate them into health care programs.

Recently, the Maternity Home in Mehalla-El-Kubra, invited the International Fertility Research Program (IFRP) to Egypt to test IFRP's pictorial birth reporting forms for traditional midwives. But the forms had been designed for use in Indonesia and had to be adapted to the local Egyptian culture.

The traditional midwives, who sometimes deliver babies in the Maternity Home, would be using the sheets in deliveries in rural areas. So the administrators turned to these women for advice on redesigning the forms. The midwives not only came up with ideas to make the sheets "more Egyptian", but they also offered some suggestions that made them clearer.

In the first figure, for example, the birth attendants criticised the drawing of the external genitalia as being too abstract. They suggested an entire female infant be drawn and denoted by a ribbon in her hair and an earring in her ear. Every female child gets a gold earring, no matter how poor her family, the midwives explained.

The woman found ludicrous the drawing that represented a dead baby (see Figure 1.61). The drawing showed an infant wrapped in a

cloth tied at both ends. It looked like a piece of store bought candy, said the midwives. They suggested wrapping the infant as a mummy, as is often the practice in Egypt. The attendants did not overlook any detail. The Indonesian form depicted a cross on the drawing of an ambulance (see Figure 1.62). An Egyptian ambulance would have a red crescent on its side, said the attendants. The revised drawing shows the ambulance with a crescent instead of a cross. These and other suggestions made by the midwives were incorporated in the sheets now being tested in Egypt."

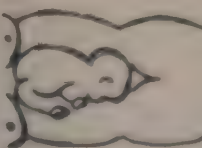
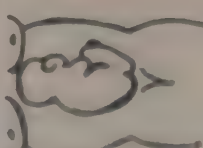
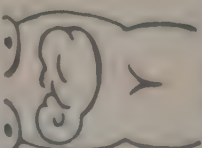
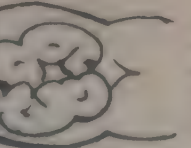
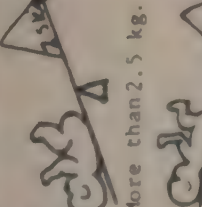
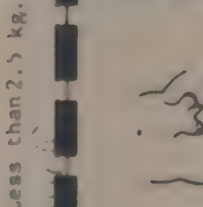
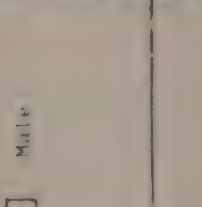


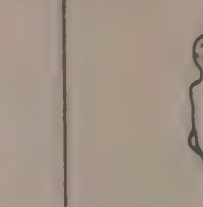
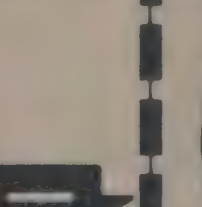

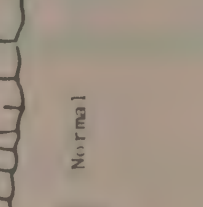


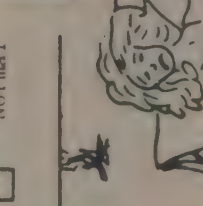
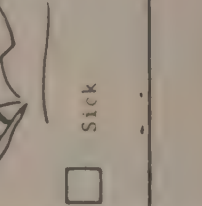
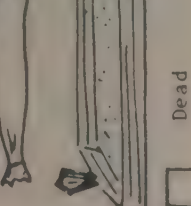
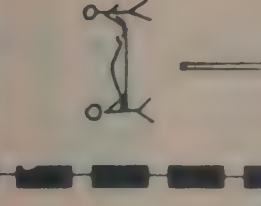

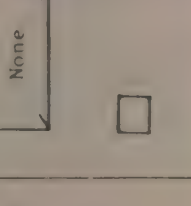
Presentation	 <input type="checkbox"/> Normal	 <input type="checkbox"/> Breech	 <input type="checkbox"/> Transverse	 <input type="checkbox"/> Multiple
Weight and Sex of Infant	 <input type="checkbox"/> More than 2.5 kg.	 <input type="checkbox"/> Less than 2.5 kg.	 <input type="checkbox"/> Male	 <input type="checkbox"/> Female
Condition of Newborn	 <input type="checkbox"/> Normal	 <input type="checkbox"/> Dead	 <input type="checkbox"/> Dead	
Maternal Bleeding	 <input type="checkbox"/> Normal	 <input type="checkbox"/> Excessive	 <input type="checkbox"/> Excessive	
Postpartum Condition	 <input type="checkbox"/> Normal	 <input type="checkbox"/> Sick	 <input type="checkbox"/> Dead	 <input type="checkbox"/> Dead
Referral of Patient	 <input type="checkbox"/>		 <input type="checkbox"/> None	 <input type="checkbox"/> None

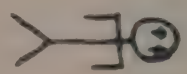

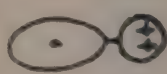

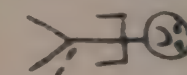


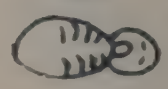
Fig. 1.61: Traditional birth attendants' reporting form used in Indonesia

نوع المحس	وزن ونسج المولود (ة)	حالة المولود (ة)	كمية الدم أثناء وبعد الولادة	حالة الأم بعد الولادة	تحول الأم للمستشفى
<input type="checkbox"/> بالقمة 	<input type="checkbox"/> أكثر من ٢٥٠٠ جم 	<input type="checkbox"/> طبيعي 	<input type="checkbox"/> كمية الدم عادية 	<input type="checkbox"/> ارتفاع في الحرارة 	<input type="checkbox"/> لم تحول
<input type="checkbox"/> بالقدم 	<input type="checkbox"/> أقل من ٢٥٠٠ جم 	<input type="checkbox"/> غير طبيعي 	<input type="checkbox"/> ووت نزيل 	<input type="checkbox"/> وفاة الأم 	<input type="checkbox"/> تحولت للولادة أو بسبب مضاعفات
<input type="checkbox"/> مستعرض 	<input type="checkbox"/> زائد 	<input type="checkbox"/> وفاة المولود (ة) 	<input type="checkbox"/> وفاة المولود (ة) 	<input type="checkbox"/> وفاة الأم 	<input type="checkbox"/> تحولت للولادة أو بسبب مضاعفات
<input type="checkbox"/> توأم 	<input type="checkbox"/> أنثى 	<input type="checkbox"/> وفاة المولود (ة) 	<input type="checkbox"/> ووت نزيل 	<input type="checkbox"/> وفاة الأم 	<input type="checkbox"/> تحولت للولادة أو بسبب مضاعفات

Fig. 1.62: Redesigned form being tested in Egypt

* Ghana, Danfa Project (1977) Traditional birth attendant training course manual. Includes a specimen record page from a TBA notebook, recording problems and complications. The TBAs designed the illustrations themselves.

Problems/complications

	maternal death	_____		eclampsia	_____
	neonatal death	_____		tear	_____
	severe haemorrhage	_____		neonatal tetanus	_____
	severe infection	_____		asphyxia	_____
Other _____					

Record of Visits




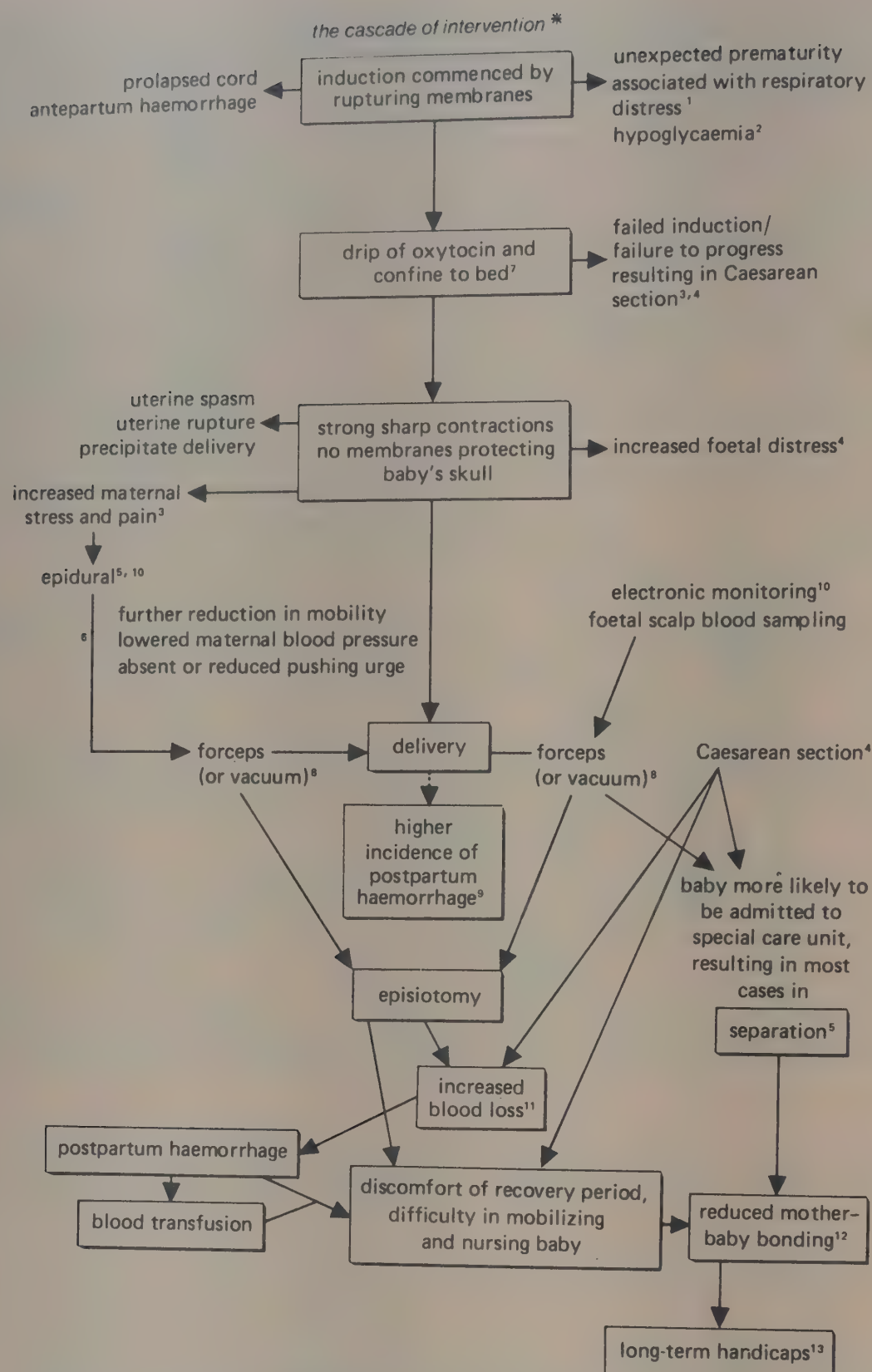
1. Prenatal		<input type="text"/>	Referrals	<input type="text"/>
2. Postpartum		<input type="text"/>	Referrals	<input type="text"/>
3. Family Planning		<input type="text"/>	Referrals	<input type="text"/>

Fig. 1.63.

* Ghana, University of Ghana Medical School (1977) Traditional birth attendant record keeping at Danfa.
Illiterate traditional birth attendants in Ghana put stones or maize in a jar to record the numbers of male and female births. The system has further possibilities: for example, one stone can be put in the jar or pot for every stillbirth and one maize grain for every livebirth. The numbers can be added up by the local school children or by their supervisor. Often local people may use numbers well because of their necessity in trading, even though they may not be able to write them.

* Inch, S. (1982) Birthrights, a parent's guide to modern childbirth.
Written by a community midwife, this book analyses the present "cascade of intervention" in delivery care, and the effects on the mother and child. The implications of the present pathology orientated maternity system are examined.



* Adapted from material supplied by A. H. MacLennan.

Fig. 1.64.

Particularly impressive are the chapters on the 3 stages of labour, which bring together recent research by obstetricians, medical sociologists and paediatricians on such topics as perineal shaving, confining labouring women to bed, position in labour, active management of labour, monitoring pain, lithotomy position for delivery, use of ergometrine and syntometrine. An important contribution to midwifery.

Kalimo, E., Barres, J.F. and Torfs, M. (1975) Use of village health workers and trained traditional birth attendants in the Department of Maradi, Niger. In Djukanovic, V. and Mach, E.P. (eds) (1975) Alternative approaches to meeting basic health

needs in developing countries: pp.78-91.

The rationale for training TBAs is given as follows: to reduce infant mortality; to improve standards of hygiene during delivery, to educate the mother in better nutrition during pregnancy and weaning, to obtain a statistical record of births, and thus to compensate for the scarcity of maternity hospitals. A trial training course run by UNICEF cost only US\$21.241 per TBA. TBAs who were trained covered 28% of all deliveries in Maradi. A dramatic improvement in the hygiene conditions in which deliveries took place was noticed.

1.3. Postnatal care

1.3.1. Early recognition and treatment of complications after childbirth

1.3.1.1. Postpartum complications in the mother

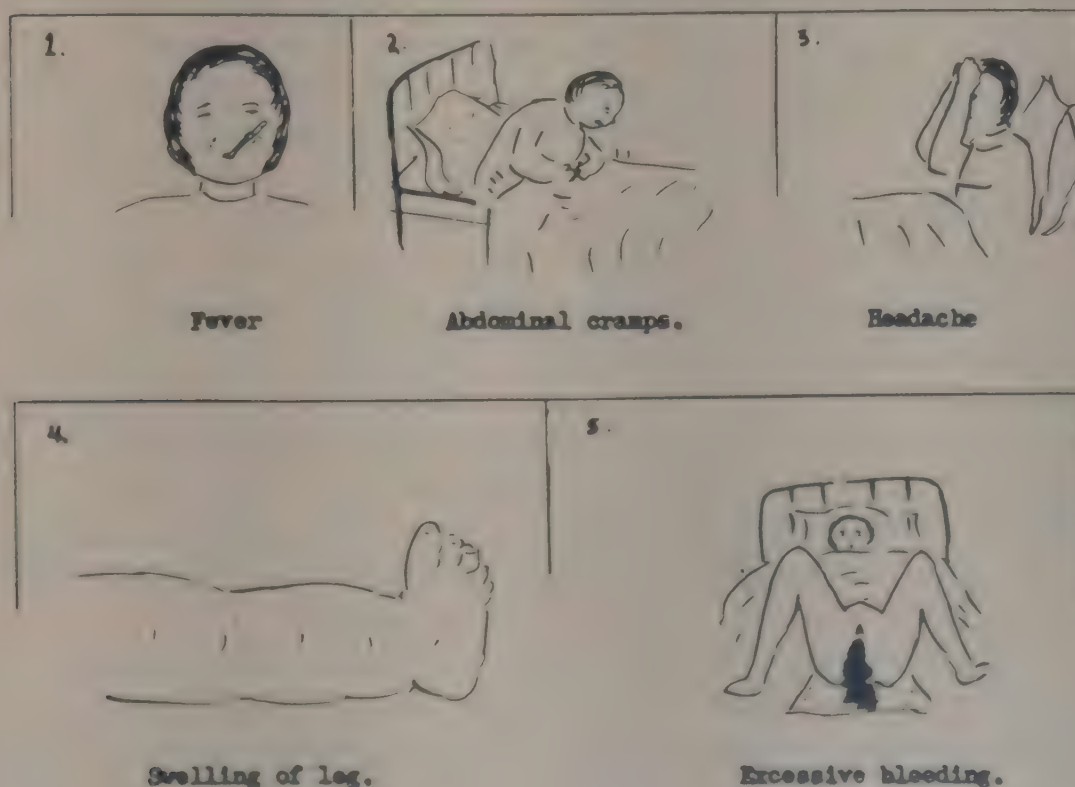
* Alaska, Dept. Health and Welfare (1966) Midwifery teaching guide for public health nurses.

Danger signs of the postpartum period are listed and illustrated on p.58: fever, abdominal cramps, headache, swelling of legs, excessive bleeding. The mother should be kept in bed and given plenty of liquids; the doctor or nurse should be notified.

If the mother's breast becomes infected, (red, swollen) a breast support should be applied and the mother put to bed with an ice "cap" for the swollen breast. The doctor or nurse should be notified.

Danger Signs of the Postpartum Period

If These Things Happen:



Do These Things:

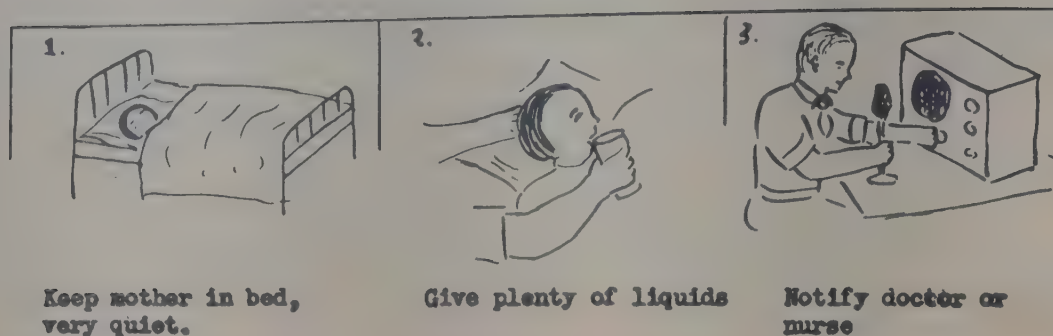


Fig. 1.65.

* Fensom, M. (1959, 4th impression 1971) Midwifery. Chapter 6 (The puerperium) deals with ways of preventing postnatal infection through cleanliness, antenatal care and intra-natal (3rd stage of labour) care. Postnatal care includes the prevention of uterine infection, breast infection, engorgement and cystitis, and treatment of these conditions if they do occur.

* Tunisia (1981) Medjez el Bab project. Maternal and child care project. Reported in Salubritas Health Information Exchange 5 (4): pl.

"Simple record-keeping guarantees postnatal care." An informed record-keeping system is described that allows clinic personnel to tell at a glance whether a mother and her infant are receiving proper postnatal care. A large wooden box is hung just inside the main door of the clinic. The box is divided into 48 slots, four for each month of the year.

When a child is born, a stiff card is written for the mother (including her name plus the date of the six week postpartum visit) and a stiff card for the child (its name plus the date of the first monthly weighing). The cards are placed in the appropriate week's slot in the box. For example, if a child is born in the first week of June the child's card is placed in the slot for the first week of July. The mother's card is placed in the third week of July, six weeks after the birth, when she is due for her postpartum check up. When the mother brings the baby to have it weighed, the weight is noted on the card. The card is then placed in the slot for the beginning of the baby's third month when the baby is due for the first vaccination. In the example of the June baby, this would be first week of September. It is immediately apparent if a mother has not come for care because her card remains in the slot for the week she or her infant was supposed to return. In this case a social worker is sent to the home, who either brings the mother to the clinic, or provides the care at the mother's home.

The cards are colour coded, for example the tip of the child's card for measles vaccine is red. The colour coding gives information at a glance on how much vaccine is needed for about 9 months ahead, also how many postnatal patients to expect each week.

* Werner, D. (1977) Where there is no doctor. Childbirth fever (Infection after giving birth): p.276.

"Sometimes a mother develops fever and infection after childbirth, usually because the midwife was not careful enough to keep every thing very clean or because she put her hand inside the mother. The signs of childbirth fever are: chills or fever, headache or low back pain, sometimes pain in the belly, and a foul-smelling or bloody discharge from the vagina. Treatment: Penicillin, 400,000 unit pills, 1 pill 4 times a day, or injections of procaine penicillin, 250,000 units, twice a day for a week. Other antibiotics (ampicillin or sufadiazine) may be used instead..."

Childbirth fever can be very dangerous.
If the mother does not get well soon, get medical help.

Pp. 277-278 describe sore nipples and breast abscess prevention and treatment.

WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse-midwife teachers. 2nd revised edition.

Relevant sections include Postpartum infection (Section 31), and the Postpartum visit (Section 32).

Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (1976) Maternite et sante: notions d'obstetrique. Fr. Chapters 24-26 deal with the puerperium. Includes infections during the puerperium, engorgement of the breast, hypolactation, mammary infections, sequelae of retained placenta.

1.3.1.2.

Postpartum complications in the baby

* Alaska, Dept. of Health and Welfare (1966) Midwifery teaching guide for public health nurses.

Illustrates some danger signs of the newborn period e.g. bleeding from the nose or mouth, pale or bluish colour, cough, bleeding from the cord. Later problems may include swelling and infection of the cord; swollen infected eyes; skin rash; sore mouth and bleeding gums; failure to gain weight.

Chan, M. (1976) Newborn Kernicterus: prevention in Singapore. A set of 24 slides from Singapore about neonatal jaundice and kernicterus. Includes G-6-P-D deficiency which is common in S.E. Asia and Mediterranean regions. The methods of preventing the disease include health education for parents on avoiding the use of herbs, fava beans, mothballs and drugs which result in the breakdown of the red cells. The management of the sick child by exchange transfusion at birth using blood collected from the umbilical cord is explained. A cassette tape is also available.

* Werner, D. (1977) Where there is no doctor.

"Problems that result after the baby is born (in the first days or weeks)": pp.272-275. Gives a very useful account of danger signs and the action to be taken for: "pus or bad smell from the navel (cord); if the skin around the cord becomes hot and red; high fever; fits; if the baby does not gain weight; vomiting." There is a further section on signs to look for if the baby stops sucking well or seems ill (including difficulty in breathing, skin

colour, sunken fontanelle, stiffness of the body etc.).

1.3.2.

Postnatal advice to parents on newborn child care, nutrition, breastfeeding, family planning etc.

See also Teaching mothers (and some fathers) about care of the newborn (Section 1.1.4.8.); Child nutrition (Section 2); Child development (Section 3); and Birth spacing (Section 4) in this bibliography.

British Columbia (1979) Baby's best chance - a perinatal manual for parents. 123pp.

The contents include sections on: (1) pregnancy; (2) prenatal care; (3) childbirth; (4) infants - care and hygiene. The authors discuss the 'forgotten' father's role.

Cobb, J. (ed.) (1980) Babyshock, a mother's first five years. Written for the UK, with practical suggestions for coping. Useful for Europe.

* **Colgate, S.H. et al.** (1979) The nurse and community health in Africa.

Health teaching and common problems in the postpartum period: pp.118-120. Includes useful notes on teaching birth spacing: i.e. the goals of healthy mothers and children, and the need for family planning education, e.g. many African mothers believe that as long as they are nursing their child they are not in danger of becoming pregnant. There is, however, no guarantee that lactation will suppress ovulation for long.

Gunther, M. (1971) Infant feeding.

Written for the public as well as for health workers; mostly for people working or living in the industrialised countries. Easy reading material for beginners.

Health Education Council, UK (?1978) How to survive the first week of breastfeeding. Pamphlet.

Intended for first-time mothers in the UK. Useful and amusingly illustrated.

* **Helsing, E and Savage King, F.** (1982) Breastfeeding in practice; a manual for health workers.

A very useful source for teaching on breastfeeding.

* **Illingworth, R.S.** (1981) Your child's development in the first five years. 72pp.

* **Leach, P.** (1977) Baby and child from birth to 5 years. Chapter 2: The newborn up to 3 months: pp.31-117.

Written for parents. Very well illustrated.

* **MacKenna, J., Polden, M. and Williams, M.** (1980) You, after childbirth, exercises and advice for the new mother.

National Childbirth Trust UK, Chiltern Branch (?1981) Have plan, will cope.

"Some of the things we wished we'd been told about what life is really like with a new baby". Suggestions on ways new parents can overcome some of the difficulties. Amusingly illustrated. Useful for Europe.

* Open University, Health Education Council, UK (no date) The first years of life, a course for parents. A series of 8 booklets covering pregnancy up to 2 years of age. The series was produced by a distinguished advisory team but the material is clearly and simply written for parents, and is illustrated with many photographs. Although it is aimed at the UK, much of it is relevant in many other countries. The full course includes 4 TV programmes and 4 radio programmes, each lasting 24 minutes, but the booklets could be used alone.

Scottish Health Education Group (1980) The book of the child: pregnancy to 4 years old. 79pp.

A book written for parents, prepared with the help of the Open University course team (see above). Covers "your pregnancy, you and your baby, and helping your child to develop".

"You and your baby", is the most relevant part for immediate postnatal education.

* Werner, D. (1977) Where there is no doctor.

Excellent sections on feeding the newborn: p.271; the best diet for small children: p.121; how a mother can produce more milk: p.271; the mother's health after childbirth (diet and cleanliness): p.276; care of the breasts and starting breastfeeding: p.277; preventing sore nipples and breast abscess: p.278.

Example: "How a mother can produce more milk"

She should:

nurse her baby more often,
drink plenty of liquids,
eat as well as possible, especially milk, milk products,
and body-building foods,
get plenty of sleep and avoid getting tired or upset."

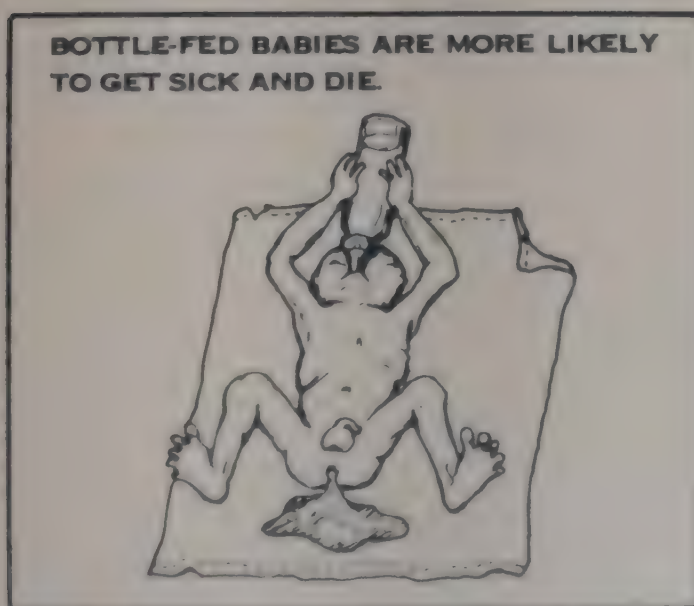


Fig. 1.66.

1.3.3. Planning, organisation and evaluation of postnatal services

* Tunisia, (1981) Medjez el Bab project. Maternal and child care project. Reported in Salubritas Health Information Exchange. 5 (4): p.1.

"Simple record keeping guarantees postnatal care".
See annotation in Section 1.3.1.1.

2. Child nutrition and promotion of food supply.



2. Child nutrition and promotion of food supply.

2.1. Finding out about child nutrition in the community

2.1.1. How do you find out if the children are growing properly?

* Brown, J.E. and Brown, R.C. (1979) Finding the causes of child malnutrition, a community handbook for developing countries. Out of print. Rewritten as: Tackling child malnutrition in the community. (1982) Contact No.69.

Section 1 raises the questions: How do you measure community malnutrition? What is your community? Appendices cover: How to measure arm circumference, (using a bracelet or Shakir strip); How to find a child's birth date (from teeth, community calendar -holidays, visits of important people, etc - or from records or brothers' and sisters' records if available); How to measure weight for age; How to measure weight for height; How to get more information; How to find out the main causes of malnutrition. Written in large type and simplified English. Very useful indeed.

* CHILD-to-Child Programme

Leaflets available include a description of the use of the Shakir strip and Activity sheets: "Our babies growing up" - school children recording births and monitoring the progress of children (1979); "Health scouts" - finding out about health needs in the community (1979). Eng. Fr. Sp. Port. Arabic.

Ebrahim, G.J. (1981) Paediatric practice in developing countries.

Chapter 5 is on measuring malnutrition, the community diagnosis of malnutrition, and intervention programmes.

King, M., King, F., Morley, D., Burgess, L., and Burgess, H. (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa.

Section 2.4: How many malnourished children are there?

Illustrations in this section include "Malnutrition is like a lump of floating ice or a hippo, only part can be seen", explaining that measures of severe malnutrition (kwashiorkor or marasmus) only reveal part of the malnutrition in the community.

London School of Hygiene and Tropical Medicine (1983+)

Assessment of nutritional status. Tape-slide sets.

Unit 1: A short written introduction to the set; Unit 2:

Techniques of anthropometric assessment, 80 slides 30 minutes

tape; Unit 3: Interpretation of anthropometric measurements, 100

slides 45 minute tape; Unit 4: The assessment of problems in the

community, 80 slides 30 minute tape; Unit 5: Work book for Units

2-4.

Measuring arm circumference using the Shakir strip and an arm bangle. Source of diagrams TCHU: these pictures may be reproduced.

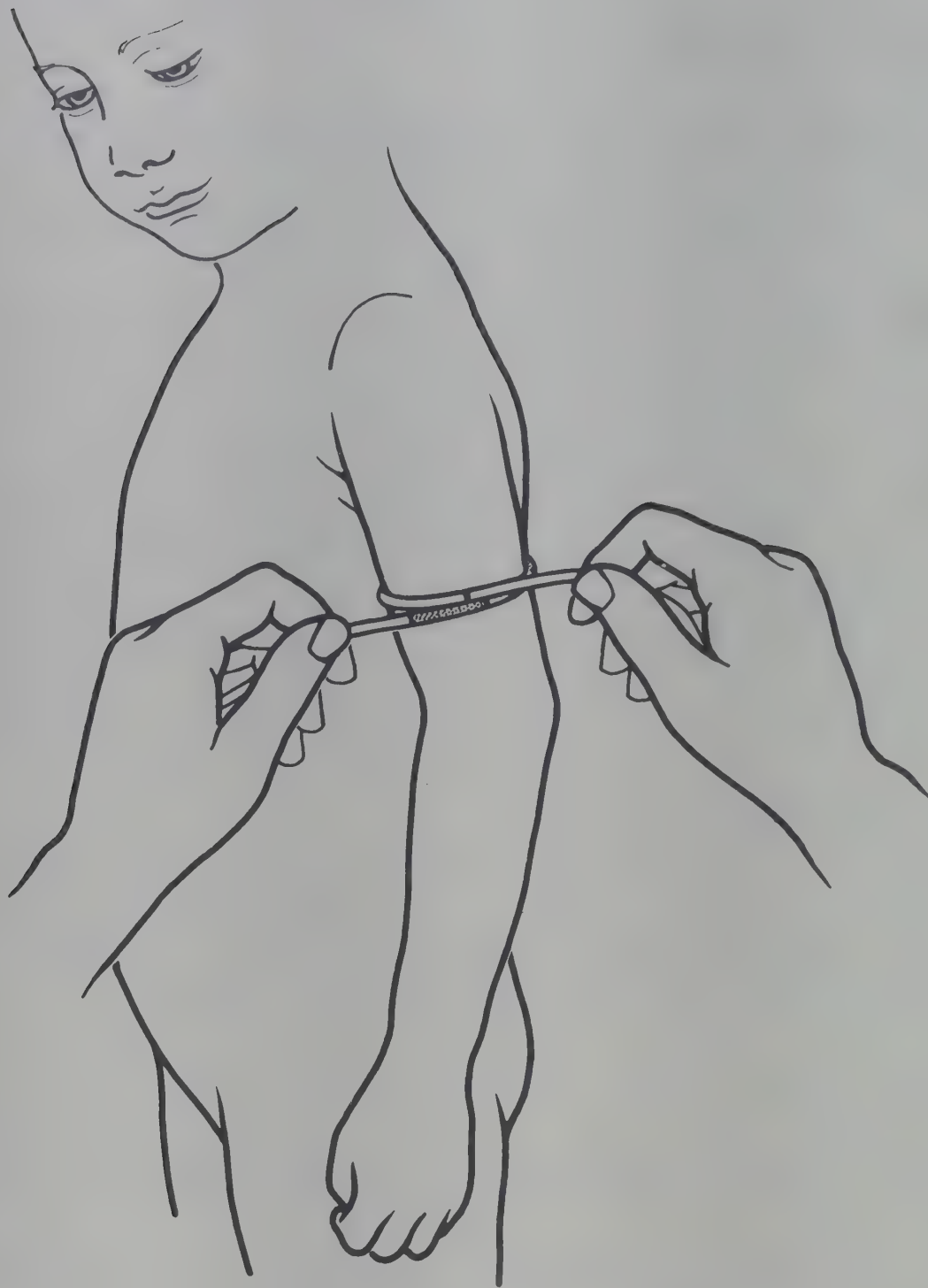
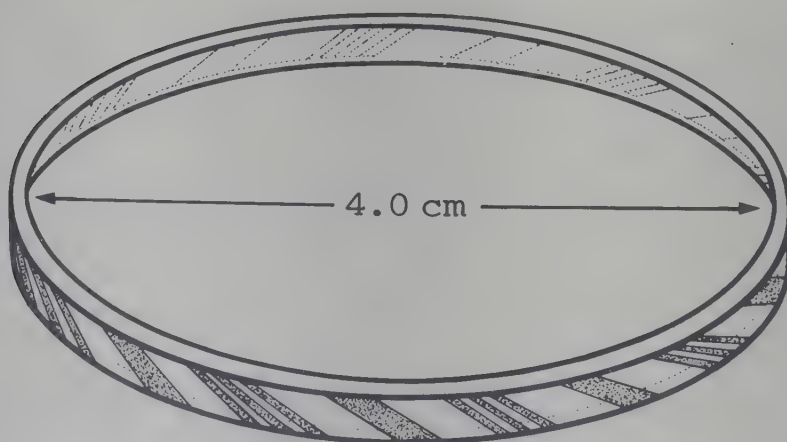


Fig. 2.1: Shakir strip

10 Anna BANGLE



Internal circumference = 12.6 cm

Fig. 2.2.

* Morley, D.C. (1969) Flannelgraph of the growth chart.

* Morley, D.C. and Woodland, M. (1979) See how they grow. Describes the growth chart as a measure of child nutrition in the community: Chapter 11: pp. 169-181. Also covers the use of an arm circumference measure. Contains very useful illustrations and many practical teaching ideas.

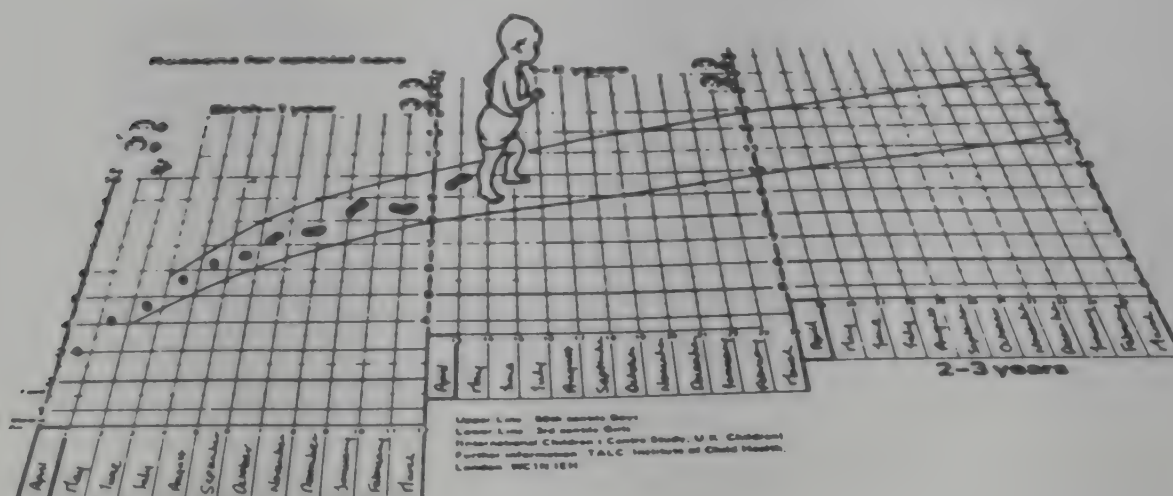


Fig. 2.3: A diagrammatic representation of the child walking across the type of weight chart described in this manual. The dots representing the growth of the child are large. They represent the child's footprints as he walks across the chart. Experience suggests that where large dots are filled in on the chart, the meaning of the curve is more likely to be understood by the health worker, and perhaps by the mother.

* Nabarro, D. (no date) Weight for height chart. Eng. Fr. Sp. Port.

Useful for identifying children who are currently thin for their height (because of recent illness or recent shortage of food). These children will reach the red section of the chart.

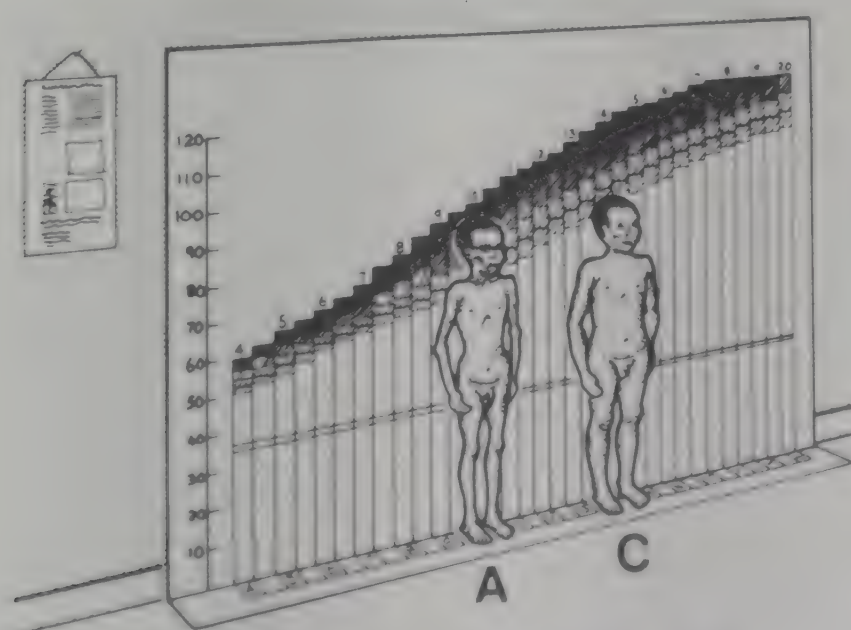


Figure 8. Boys A and C are the same height, but C's weight is the standard weight for his height while A's is 70-80% of the standard. A's target weight is 14 kg.

Fig. 2.4: Identifying thin children.

Nabarro, D. and McNab, S. (1980) A simple new technique for identifying thin children: a description of a wallchart which enables minimally trained health workers to identify children who are so thin, or wasted, that they require immediate nutritional help. J.Trop. Med. Hyg. 83: pp.21-33.

Ross Institute (1970) Protein calorie malnutrition in children. Bulletin No.12.

Photographs of protein-calorie malnutrition: p.5.

* TALC (1982) Echeverri tape for arm circumference measurement.

* TALC (no date) Growth chart stencil. Eng. Fr. Sp. Port. Arabic.

For producing paper copies locally, to use in a nutrition survey.

* TALC (no date) Plastic overlay sheets for growth chart. To be used with the growth chart, for counting children below a certain weight for their age, in a community survey.

* TALC (1974) Road to health chart, overhead projection version.

TALC (no date) Teaching health workers about arm circumference.

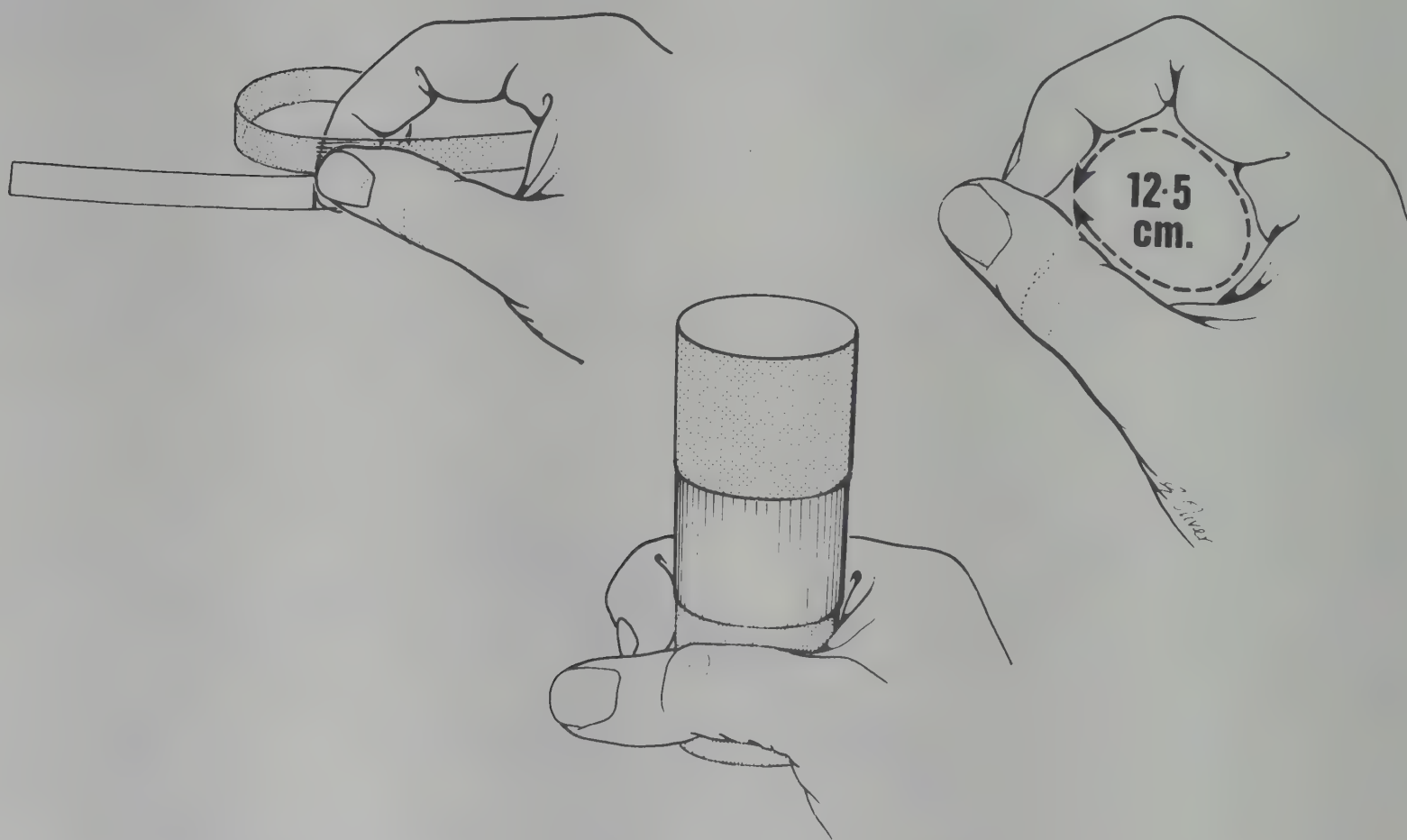


Fig. 2.5: Learning to measure thinness with your fingers. (TALC illustration)

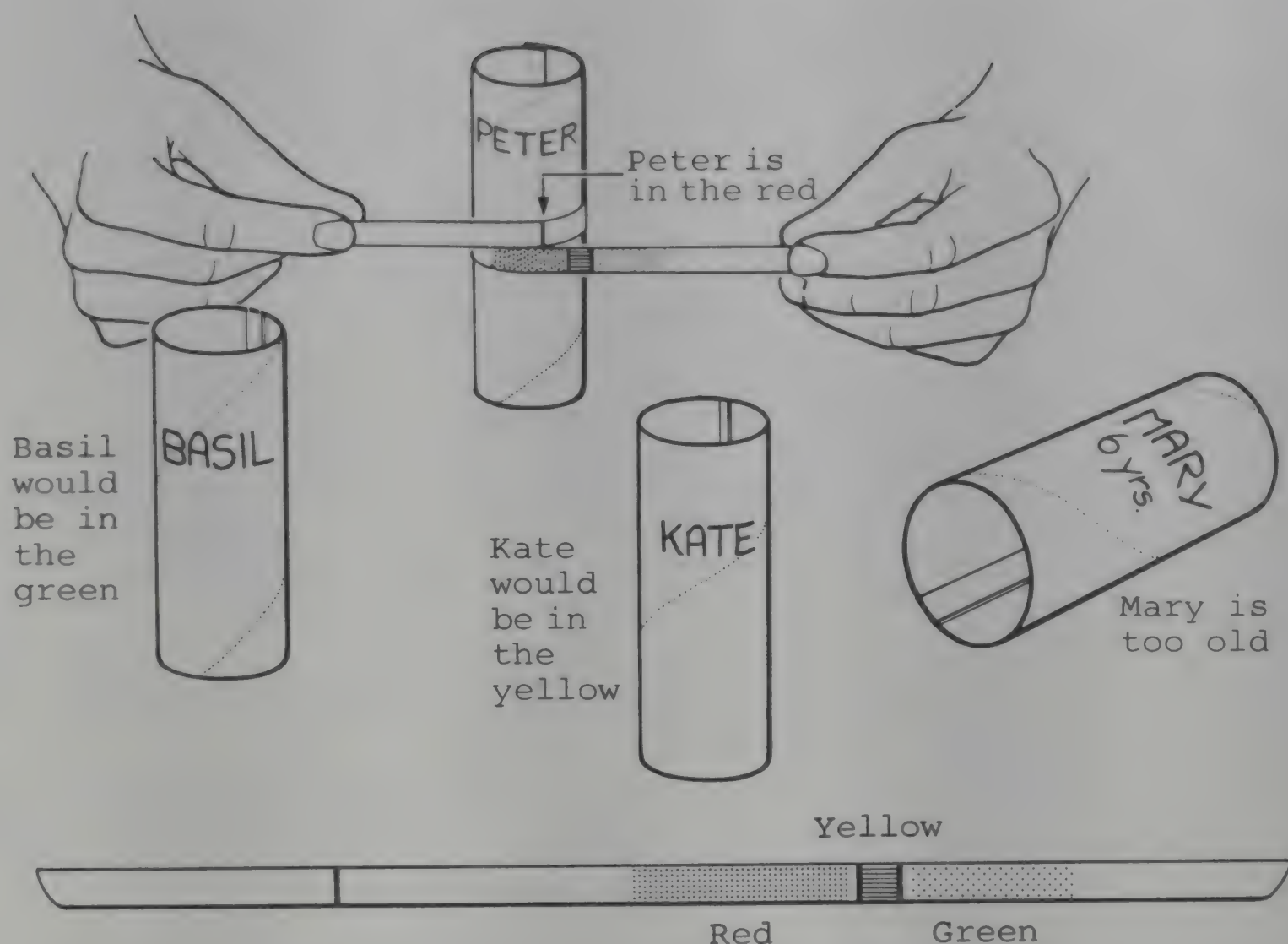


Fig. 2.6: Learning to use the Shakir strip on cardboard rolls (or cylinders of wood, maize cobs etc). (TALC illustration)

UNICEF (1982) How are the children growing?
Draft manual on the collection and analysis of weight for age data about groups of children.

* Werner, D. (1979) Where there is no doctor.
How to use the road to health chart: p.300.

* WHO (1983) Training in recording the child's growth.
EPI/PHW/83/TM.1. Eng. Fr. 32pp.
A useful booklet which brings together adaptations of parts of:
Guidelines for nutrition training of primary health care workers (1981) WHO Offset Pub. No. 59; WHO growth chart for international use (1978); and Morley, D.C. and Woodland, M. (1979) See how they grow. It is well illustrated and contains many practical case studies.

* Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (1977) Growth chart teaching pack.
Includes a poster.

2.1.2.

What are the food problems in your community?

* Brown, J.E. and Brown, R.C. (1979) Finding the causes of

child malnutrition. Out of print. Rewritten as: Tackling child malnutrition in the community (1982) Contact No.69. Section II: pp. 11-18: What questions should you ask? and whom should you ask or watch to find out about food problems in your community? The right questions to ask and the way to put them are described in detail. Do not ask: What does your family eat? Instead ask: What did you eat since this hour yesterday? or What did your husband eat? What did your little children eat? or What did your older children eat? The idea behind asking these "good" questions is that "bad" questions can lead to confusion and misunderstanding. Good questions are directly addressed to the people themselves. Bad questions are generalised, complicated and indirect... The focus is on questions about malnutrition caused by social and economic factors, because infection, disease and malnutrition are dealt with very well in other books". This whole section is excellent and very easy to understand. See also Section 2.1.1. of this bibliography.

* **Dearden, C., Harman, P., and Morley, D.C.** (1980) Eating more fats and oils, a step towards overcoming malnutrition. Tropical Doctor 10: pp.137-142. Health workers in the community may still be talking only about a 'protein gap'. It is the 'energy gap' which needs emphasis. When insufficient food is available, proteins are merely 'burnt up'. They need to be supplemented by other foods.

* **den Hartog, A.P. and van Staveren, W.A.** (1979) Field guide on food habits and food consumption. A survey protocol on how to collect information on food habits and food consumption in developing countries. Very useful for organisers, but the text is typed more closely than is desirable.

* **FAO** (circa 1978) Food and Nutrition Journal. Special Issue. A useful review of the effect of malnutrition in slowing mental development.

Gordon, G. (In press) Dawadawa power, Nutrition in the Savannah of West Africa. Contains a chapter on finding out about child feeding practices.

King, M., King, F., Morley, D., Burgess, L. and Burgess, H. (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa. Contains many useful sections, e.g. What are the blocks in the food path? (Section 9.25). Outlines questions to ask families and includes a very useful diagram of some of the problems that can block the path between growing food and the child eating and using it. The blocks include: people being too sick to grow food; too many people with insufficient land; some farming customs; spoilt food stores; alcohol; a short birth interval; unfair sharing of food. Most malnutrition is the result of several blocks in the food path.

* **Morley, D.C. and Woodland, M.** (1979) See how they grow. Recognises the major problems of child nutrition and offers the appropriate advice.

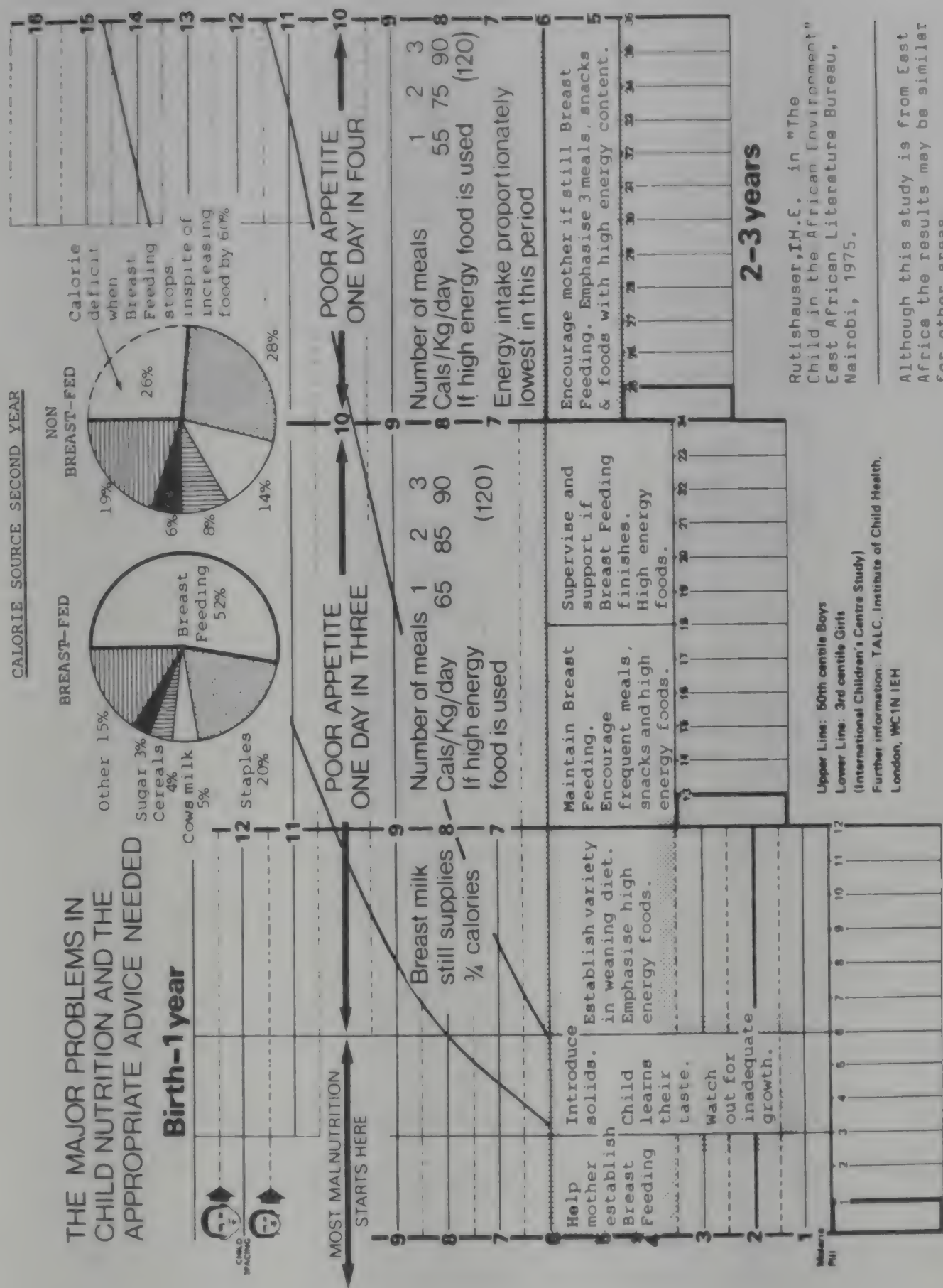
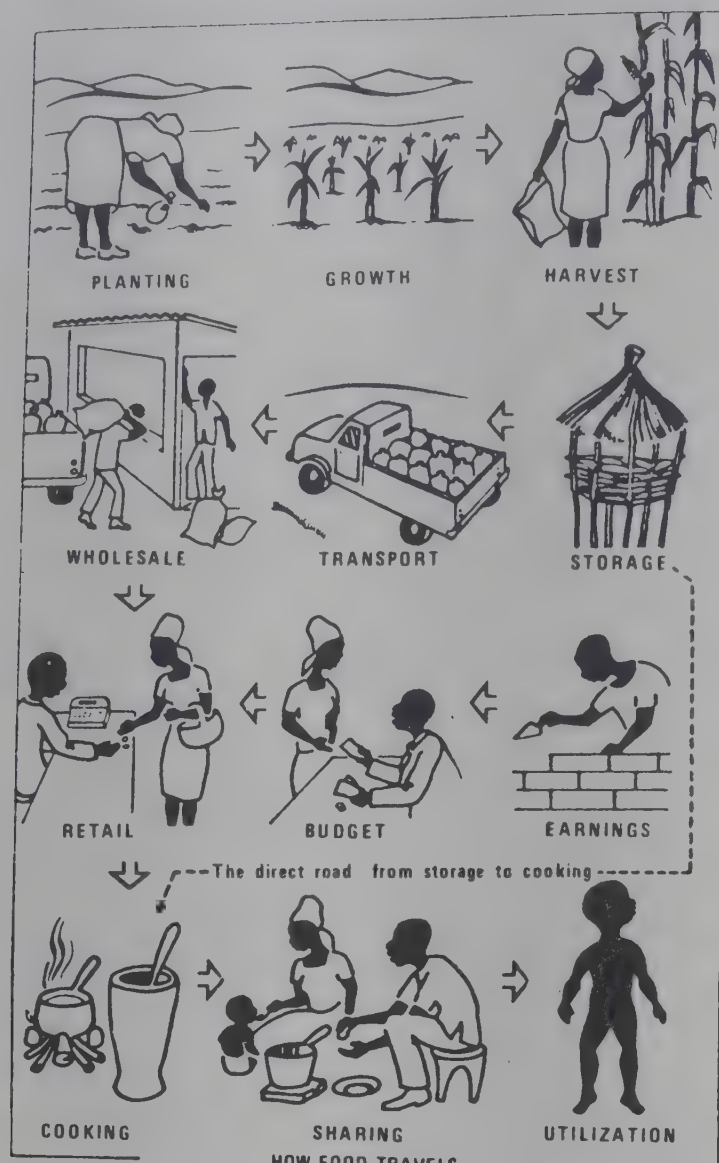


Fig. 2.7: This may be reproduced.

Raimbault, A.M. (1980) Health habits: a learning experience. Children in the Tropics No.128: p.6.



«Les troubles nutritionnels chez la mère et l'enfant»,
H. Dupin, A. M. Raimbault, St. Paul, p. 51.

Fig. 2.8: Illustration adapted from the food path in King, M et al. (1972) Nutrition for developing countries.

2.1.3. Learning about some of the causes of malnutrition

2.1.3.1. How does infection affect malnutrition?

Brown, J.E. and Brown, R.C. (1982) Tackling child malnutrition in the community. Contact No. 69. 21pp.
Includes: How do you measure child malnutrition in the community? What is your community? How many children should you measure? What should you measure? What are the food problems in your community? What questions should you ask? Whom should you ask or watch? Which problems should you attack? (Also has useful list of books about nutrition and agriculture and community development.)

Ethiopia, Ministry of Health (1981) Mother and child nutrition.

This booklet explains the importance of energy and bodybuilding foods for children under five and pregnant and lactating mothers. Weaning foods based on the local staples are described. Protection from infections that lead to malnutrition are shown. Many pictures and posters from the Ethiopian Nutrition Institute are included.

Khan, M.A. and Baker, J. (1981) Nutrition in primary health care.

A locally produced booklet from Pakistan, with some illustrations. It covers nutrition and the community; breastfeeding; diarrhoea and nutrition; nutrition and infections.

* **King, M.** (1978) Primary child care, a manual for health workers. Book 1.

Explains that children who lack vitamin A may suddenly get keratomalacia (dryeye, greyness or softness of the cornea of the eye) when they suffer an infection or severe malnutrition. This can lead to blindness. Prevention and treatment are outlined on p.191.

* **Morley, D.C.** (1973) Paediatric priorities in the developing world.

The effects of whooping cough and malnutrition together are explained clearly using a growth chart: pp.238-240.

* **Ritchie, J.** (1984) Nutrition and families.

An excellent revision of a book originally produced by FAO, Addis Ababa.

WHO (1981) Guidelines for training community health workers in nutrition. WHO Offset Pub. No.59.

The diarrhoea infection nutrition complex is described particularly well.

* **Zambia, National Food and Nutrition Commission** (no date) Growth chart poster.

A healthy child increases in weight, and drops in weight with sickness.

2.1.3.2.

Socioeconomic factors and malnutrition

* **Brown, J.E. and Brown, R.C.** (1982) Tackling child malnutrition in the community. Contact No.69.

Analyses the underlying socioeconomic causes of malnutrition.

* **Morley, D.C. and Woodland, M.** (1979) See how they grow.

The socioeconomic background of malnutrition: pp.70-71. Includes a useful illustration of a growth chart showing the stories of Aina and Assa: Aina came from a poor family and, for a combination of reasons, did not grow well.

* **Oxfam** (?1980) The poverty game.

A game for between 8 and 30 people. Its objectives are to give an understanding of:

- 1) The vulnerability of the subsistence farmer to change.
- 2) The difficulty of taking decisions in this precarious situation.
- 3) The vicious spiral of misfortune, poverty, malnutrition and disease.

* **Solon, M. and Burgess, A.** (1979) Malnutrition in an urban environment.

A set of 24 slides and script. A cassette tape is also available. The programme is aimed at a wide range of workers, including non-medical, concerned with nutrition in the community. The slides tell the story of a family and its neighbourhood in the Philippines. The message is that attention should be paid to poverty as a main cause of under-nutrition and infection.

* **Werner, D and Bower, B. (1982)** Helping health workers learn. A book of methods, aids and ideas for instructors at the village level.

Part 5, Chapters 25-27: Health in relation to food, land, and social problems. Suggests that hunger is due not to shortage of land or food, but to unfair distribution.

2.1.3.3. Low birth weight and the cycle of undernutrition

* **TCHU (1981)** The cycle of undernutrition. A picture by Morley, D.C.

A diagram to show how low birth weight can lead to poor growth in infancy and stunting as an adult, which in turn can lead to low birth weight children.

THE CYCLE OF UNDERNUTRITION

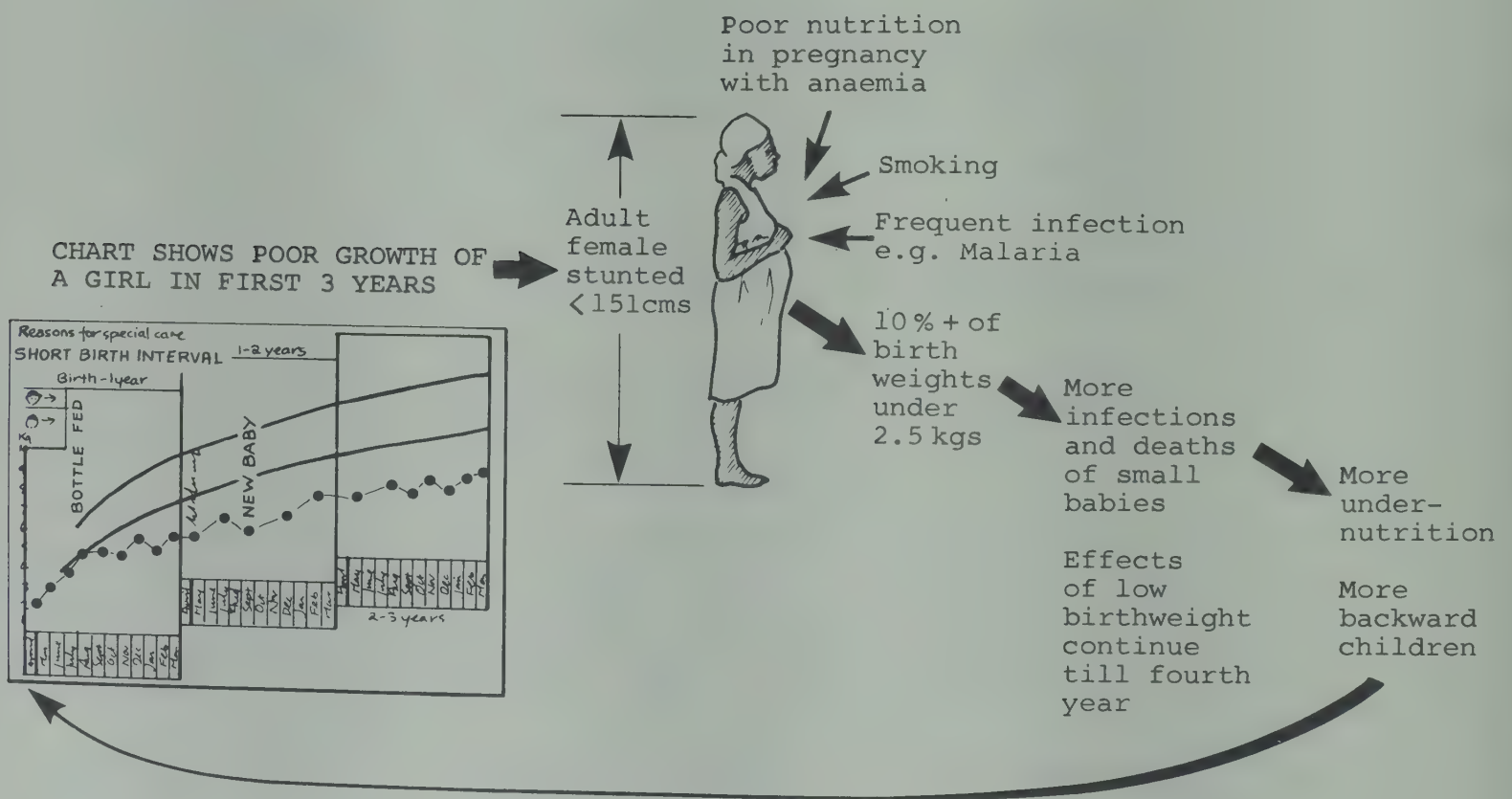


Fig. 2.9: This picture may be reproduced.

2.1.3.4. Closely spaced children and malnutrition

Morley, D.C. (1973) Paediatric priorities in the developing world.

Chapter 18 is devoted to birth interval.

Ross Institute (1970) Protein calorie malnutrition in children. Bulletin No.12.

Factors contributing to malnutrition in children are discussed, including: malaria, worms, infections, closely spaced children, bottle milk, etc. Recommendation for avoiding malnutrition include: better cooking, the mixing of available foods (e.g. legumes with staples), and breastfeeding. Some recipes for feeding children under five are given in the appendices. The book is well illustrated with pictures and diagrams.

2.1.3.5.

Seasonal factors and malnutrition

Sinha, D.P. and Bang, F.B. (1973) Seasonal variation in signs of vitamin A deficiency in rural West Bengal children. Lancet 2: p.228.

* Wood, C.H., Vaughan, J.P., de Glanville, H. (1981) Community health.

Chapter 11: Nutrition and health. Discusses seasonal factors affecting nutrition: e.g. the rainy season. In many areas this is the time for planting when work is hard and long hours of farming are required. It is also a time when diarrhoea may increase due to the contamination of water supplies. There is little time to care for the sick or to prepare food. Food may also be short because stores are low or non-existent until the newly planted crops are harvested.

2.1.3.6.

Breast milk substitutes and malnutrition

Chetley, A. (1979) The baby killer scandal. A War on Want investigation into the promotion and sale of powdered baby milks in the third world.

Considers possible hazards of bottle feeding under unhygienic conditions. Recommendations from the WHO/UNICEF meeting on infant and young child feeding are given in Appendices II and III.

Cottingham, J. (1976) Bottle babies: a guide to the baby food issue.

Griener, T. (1975) The promotion of bottle feeding by multi-national corporations.

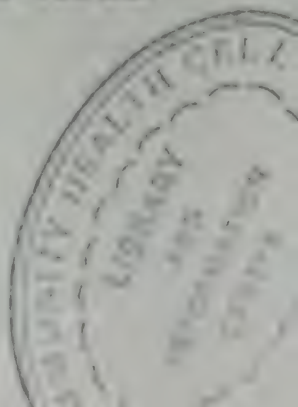
Discusses the role of the health professions in promoting bottle milk, and the problems it can cause.

Melrose, D. (1981) The great health robbery - baby milk and medicines in Yemen.

A local investigation into baby milk promotion in a setting where it is not appropriate to children's health.

* Muller, M. (1975) The baby killer. 2nd edition. 21pp.

Describes the dangers of bottle feeding. An investigation into the promotion and sales of powdered baby milks in the third world.



2.1.3.7. Goitre and cretinism

* Pharaoch, P. et al. (1981) Goitre and cretinism. A set of 24 slides with text. A cassette tape is also available. This slide set illustrates the symptoms, signs and management of endemic goitre and cretinism. The slides are mainly for public health workers and nutritionists, in areas where iodine deficiency is a problem. The first 13 slides cover endemic goitre, the next 7 cover endemic cretinism and the last 4 cover the control of both endemic goitre and cretinism.

2.1.3.8. Lack of fibre, and malnutrition

Burkitt, D.P. (1977) Fibre: Its importance in human nutrition.

A set of 24 slides and text. A cassette tape is also available. An epidemiological account of diseases related to lack of fibre in the diet. These include diverticular diseases, ischaemic heart disease, adenomatous polyps, gall stones, deep vein thrombosis, etc. The major point made is that these diseases are rarer in rural communities of the third world, where people consume adequate fibre in their diet than in the Western countries where food processing eliminates fibre.

2.1.3.9. Child anaemia

* VHAI (no date) Anaemia recognition card. Many languages. A useful chart with pictures of tongues, to assist in the recognition of anaemia.

* VHAI (1977) Better child care. 48pp. Many Indian languages and Eng. Contains a good section on infant feeding and the need for dark green vegetables in a child's diet. A version for Ghana is also available.

* WHO (1975) Control of nutritional anaemias with special reference to iron deficiency. Tech. Rep. Ser. 580.

2.1.3.10. Blinding malnutrition, vitamin A deficiency (xerophthalmia/keratomalacia)

There is little clear practical low cost material for middle level personnel, although an extensive technical literature exists.

Begum, A. and Pereira, S.M. (1976) The beta carotene content of Indian edible green leaves. Trop. Geog. Med. 29: p.47.

Bisley, G.G. (1980) Handbook of ophthalmology for developing countries.

* CHILD-to-child Programme (?1980) Looking after eyes. A 4 page pamphlet intended for children looking after younger children, but which would also be useful for other groups of

people. There is a small section on avoiding Vitamin A deficiency.

Galbraith, J.E.K. (1979) Basic eye surgery. A manual for surgeons in developing countries.

* Helen Keller International (no date) Conquering xerophthalmia (prototype training series):

Saving a child from xerophthalmia: a disease of darkness (8 frame film-strip).

Know the signs and symptoms of xerophthalmia.

* Xerophthalmia: clinical appearance, treatment and prevention schedule (colour slides).

* Prevention of xerophthalmia and nutritional blindness. Manual for health and nutrition aides (40 slides).

* Clinical characteristics and management of xerophthalmia, a teaching guide for physicians and medical students (20 slides).

* Manual for training health workers in the recognition, treatment and prevention of vitamin A deficiency: signs and symptoms of nutritional blindness (100 slides and manual). Rather a long treatment of this topic, and slightly expensive.

* Colour identification - signs of xerophthalmia (pamphlet). Very good, but does not cover management and treatment.

International Agency for the Prevention of Blindness (1980) World blindness and its prevention.

A useful work of reference for national programme planners. Definition of/and strategy for coping with blinding malnutrition: pp.3-5. The book would be too brief and sketchy for use at health centre/clinic level.

King, M. (1978) Primary child care, a manual for health workers. Book 1.
Section 16.13: Vitamin A deficiency.

League for International Food Education (1976) Small scale intensive food production, workshop proceedings.

* Morley, D.C. and Woodland, M. (1979) See how they grow. Vitamin A deficiency: pp.71-73. Includes a picture of the weight chart of a child blind from keratomalacia due to vitamin A deficiency. The majority of such children show inadequate growth and some degree of marasmus.

* Oomen, H. and Beyda, V. (1975) Xerophthalmia slide set. 24 slides, with text. A cassette tape is also available. Very useful indeed.

Rodger, F.C. (1981) Eye disease in the tropics.

Solon, S.F., Fernandez, T.L., Latham, M.C. and Popkin, B.M. (1979)

Control of vitamin A deficiency in the Philippines. Planning, implementation and evaluation of a fortification programme. Journal of the American Dietetic Association 74: pp.112-118. The epidemiology and prevalence of vitamin A deficiency was studied, then a pilot project set up and its effectiveness evaluated prior to planning a national programme.

Sommer, A. (1974) Assessment of xerophthalmia and the mass vitamin A prophylaxis programme in El Salvador. Project report.

* Sommer, A. (1978) Field guide to the detection and control of xerophthalmia. Contains useful photographs, but the text would be difficult for middle level people and the book is expensive. It is more geared to epidemiological assessment and to national programmes.

Sommer, A. (1982) Nutritional blindness, xerophthalmia and keratomalacia. 262pp.

* VHAI (1977) Better eye care. A small booklet, written for teaching village health workers, with photographs and short descriptions on each page. e.g: "A healthy child can see in the dawn and the dusk. But this child cannot see in dawn and dusk. He is night blind. He does not like bright light. This child may become blind after more time. To prevent this his mother should give him more food. The child should eat green leafy vegetables every day..." pp.43-48 are useful. Supplementary posters are also available from VHAI.

Voorhoeve, H.W.A. (1966) Xerophthalmia in the presence of Kwashiorkor in Nigeria. Trop. Geog. Med. 18: pp.15-19.

WHO (1981) Blindness prevention: training auxiliary personnel in eye care. WHO Chronicle 34: p.332.

WHO (1980) Methods of assessment of avoidable blindness. WHO Offset Pub. No.54. Useful for reference purposes.

WHO (1980) Periodical distribution of vitamin A: delivery systems. Nut/80.23.

WHO (1980) The role of education in the prevention of vitamin A deficiency. Nut/80.15.

WHO (1980) Training of personnel: public and political awareness. Nut/80.28.

WHO (1982) Vitamin A deficiency and xerophthalmia. Tech. Rep. Ser. No. 672. Useful for reference purposes.

WHO/PAHO (1979) Evaluation of sugar fortification with vitamin A at the national level in Guatemala. PAHO Scientific Pub. No.384.

* WHO, Regional Office for the Western Pacific (1979) The

health aspects of food and nutrition. 3rd. edition.
Also useful for topics other than blinding malnutrition.

2.1.3.10.i. Measles and blinding malnutrition

International Children's Centre (1978) Measles, material for health education.

Morley, D.C. (1976) Severe measles.
24 slides with text. A cassette tape is also available.
Describes why measles is such a killing disease in developing countries.

2.1.3.10.ii. Newsletters

Rural Eye Health (quarterly) International Centre for Eye Health, 27-29 Cayton Street, London EC1V 9EJ, UK.
Contains useful articles e.g. on severe measles and its effects on eyes.

Xerophthalmia Club Bulletin (quarterly) Club Secretary, 31 Observatory Street, Oxford, UK.
Contains useful articles for nurses, especially on current treatment of xerophthalmia.

2.1.3.11. Unhealthy new habits and malnutrition

* Werner, D. and Bower, B. (1982) Helping health workers learn. pp.7-4:

"Examples of health problems that result when old customs are replaced by less healthy ones.
For hundreds of years, millet was the main food in many parts of Africa. As a whole grain it provided most of the vitamins and protein people needed. But today in much of Africa, people mainly grow and eat cassava. This new food, introduced from Latin America, is easier to grow but less nutritious than millet. It fills children with water and fibre before they get enough calories (energy). So in areas where cassava is now grown instead of millet, more children are malnourished.



Fig. 2.10: Healthier local tradition.



Fig. 2.11: Unhealthy new custom.

In many parts of the world, people spend money on expensive 'junk foods' instead of eating local fruit and other nourishing foods. 'Junk foods' are pre-packaged snacks, sweets, and drinks that are high in sugar and low in nutrients. They cause poor nutrition, rotten teeth, diabetes, heart problems, and other ills. Around the world, people tend to have much worse teeth than their ancestors did - largely because of sugar and 'junk foods'.

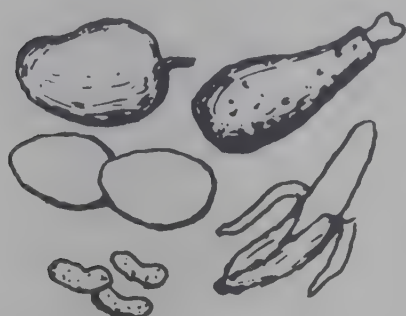


Fig. 2.12: Healthier local tradition.



Fig. 2.13: Unhealthy new custom.

Bottle feeding and the use of artificial, canned, and powdered milks have become popular in many parts of the world, in spite of the fact that the old tradition of breastfeeding is safer, better, and cheaper. (see *Where there is no doctor*: p.121). The popularity of bottle feeding is partly due to promotion by international companies, like Nestles. They continue pushing their products with misleading advertising despite widespread protest. Some countries, such as Papua New Guinea, have forbidden the sale of baby bottles without a doctor's prescription.



Fig. 2.14: Healthier local tradition.



Fig. 2.15: Unhealthy new custom.

In many countries people no longer eat whole-grain foods, such as whole wheat or unpolished rice. They have grown used to the newer, whiter, factory-milled flours and grain. Because these are far less nutritious, health problems have developed. Even so, many people who used to grow and eat their own grain now sell their whole-grain crops to buy refined flour. In a similar way, a less nutritious white hybrid maize has replaced native yellow maize in much of Latin America. (see p.15-5)."

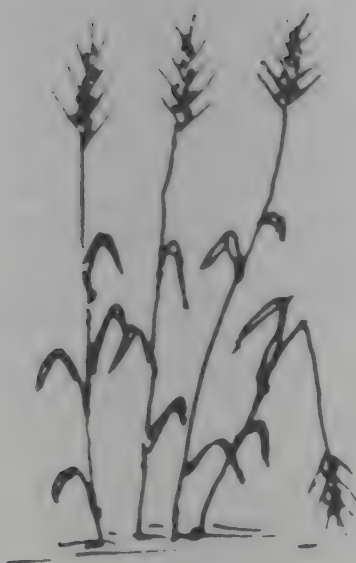


Fig. 2.16: Healthier local tradition.



Fig. 2.17: Unhealthy new custom.

2.2. How can child nutrition problems be tackled?

2.2.1. Choosing which child nutrition problems to tackle

* Brown, J.E. and Brown, R.C. (1979) Finding the causes of child malnutrition. Out of print. Rewritten as: Tackling child malnutrition in the community. (1982) Contact No.69. Chapter III: Which problems should you attack?: pp.19-28. Every community has its own problems and every community needs a plan to deal with its problems. This chapter includes stories of how six communities tackled their nutrition problems. Some plans were no good because mothers could not afford to buy the food recommended by the nutrition workers. A good nutrition plan needed to attack this problem, perhaps by cooperative purchasing.

* King, M., King, F., Morley, D., Burgess, L. and Burgess, H. (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa. Section 10.1: The educational diagnosis: Step 1 - learning about the people we teach; Step 2 - making a nutrition education plan; Step 3 - making friends with the people we teach; Step 4 - finding people's wants; Step 5 - showing people that they can sometimes have what they want; Step 6 - recording health education; Step 7 - evaluating health education. See also section 11.12: District nutrition plan.

* Werner, D. (1977) Where there is no doctor. Using local resources to meet needs and deciding what to do and where to begin: pp. W12 and W13.

POSSIBLE WAYS TO WORK TOWARD BETTER NUTRITION

FAMILY GARDENS

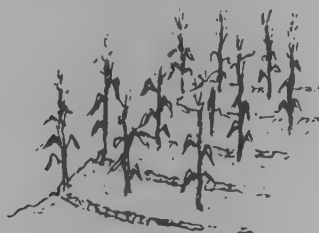


CONTOUR DITCHES
to prevent soil from
washing away



ROTATION OF CROPS

Every other planting season plant a crop that returns strength to the soil—like beans, peas, lentils, alfalfa, peanuts or some other plant with seed in pods (legumes).



This year maize



Next year beans

Fig. 2.18.

2.2.2. Treating infection, preventing disease and monitoring growth

2.2.2.1. Running an under fives clinic and treating infection

See also Section 2.1.1. Finding out about growth of children in the community.

* Balldin, B., Hart, R., Huenges, R. and Versluys, Z. (1981) Child health; a manual for medical assistants and other rural health workers.

Chapter 7: Child care in maternal and child health care.

MCH is defined as the provision of primary health care for mothers and children. The activities specific to MCH include: registration, weighing, immunisation, examination and advice, health and nutrition education for children, and antenatal and child spacing activities for mothers. The organisation of MCH involves many health workers (both medical and paramedical). To be effective, MCH care should: be provided every day; cover a wide area (possibly through mobile clinics); be recorded adequately (including home records for children); focus on the weighing, immunisation, nutrition assessment and education of children; recognise mothers and children at risk and refer those at high risk; treat the commonest problems of ill health.

* Coordinating Agency for Health Planning (CAHP) (1974) Starting an under fives clinic.

* Gordon, G. and Gordon, S. (1981) Nutrition and child health flannelgraphs.

These flannelgraphs and scripts cover 7 topics; Using flannelgraphs to communicate ideas in nutrition health; Come to

the child welfare clinic; Measles; Learning to eat; Give your child plenty of soup; Feed your child 3 times a day; Diarrhoea - Prevention and home management. They are designed for the Savannah of West Africa.

Headlam, S. (1980) Child care.

A booklet with no diagrams, produced for use in Bangladesh. Covers about 30 topics in child health, their management and prevention. Also covers the use of local herbs (treatment of scabies with 'nim' leaves, for instance).

King, M. (1978) Primary child care, a manual for health workers. Book 1.

Care of the sick and the healthy child.

King, M., King, F. and Martodipoero, S. (1979) Primary child care. A set of 240 slides and explanatory script. 35pp. A cassette tape is also available.

Designed to support "Primary child care: Book 1".

* Morley, D.C. (1973) Paediatric priorities in the developing world.

Chapter 19: The under fives clinic. Describes comprehensive child care.

* Morley, D.C. and Woodland, M. (1979) See how they grow.

Chapter 3: The layout of the growth chart, and Chapter 4: Weighing children.

WHO (1978) A growth chart for international use in maternal and child health care. Guidelines for primary health care personnel.

WHO (1977) Posters and labels for medicine containers for illiterates; diarrhoea, fever/malaise, cough, open wound, eye drops, headache.

A suggested system to help illiterate health workers identify medicines. Alternatively, they can be taught to recognise the smell of each medicine; this method has been used for teaching traditional birth attendants for many years.

* Zambia, National Food and Nutrition Commission (no date)

Growth chart: poster of the road to health chart. Useful.

2.2.2.2.

Running a community based weighing programme

* Hendratta, L. and Johnston, M. (1978) Manual for a community based under-fives weighing programme. 28pp.

Describes how a "community based" nutrition programme was started when it was realised that changes in nutrition practices can only occur if the people in the community reach a decision and act on it. Three main observations have been made: (1) A community is very interested and keen to learn and do something about nutrition if local people understand the problem and make their own assessment of nutritional status. (2) Weighing programmes for

under-fives prove to be a very effective vehicle for providing basic understanding and creating community interest in nutrition. This is because a weighing programme is simple to carry out, easy to understand, and provides a good opportunity for nutrition education. (3) The involvement and support of local community leaders is crucial for the success of the programme. In order to obtain their support the programme must "make sense" to them and must include simple monitoring tools (e.g. growth charts or arm circumference bands) that will enable local leaders to assess the programme and to give it direction. Organisation of a nutrition programme and steps in programme implementation are described on pp.8-10.

2.2.2.3. Helping older children look after younger children better

* **Aarons, A., Hawes, H. and Gayton, J.** (1979) CHILD-to-child. A book. Also: Free leaflets.

In many countries, older children have to look after younger ones when they are sick. A collection of teaching material for these older children has been developed to help them to do their "job" better. Most of it is in the form of games for the older children so the "learning" becomes incidental. The section of the book and the leaflet on caring for children who are sick gets each of the older children to tell a story of what happened when a sibling became ill. In this way a "story of malaria" or a "story of whooping cough" can be built up. The older children can be shown how they can help a sick child - giving a drink to a dehydrated child, cooling a young child with fever, etc. Other sections (and leaflets) cover many aspects of preventing ill health and monitoring growth.

2.2.2.4. Where diarrhoea is a problem, running an oral rehydration programme

See also Section 7.3. Care of the child with diarrhoea.

It is self evident that if diarrhoea is treated early, children will recover and start eating again earlier.

* **WHO** (1981) Guidelines for training community health workers in nutrition. WHO Offset Pub. No.59.

The chapter on diarrhoea is very useful.

* **WHO** (1980) Guidelines for the trainers of community health workers on the treatment and prevention of acute diarrhoea. WHO/CDD/SER/80.1.

2.2.2.5. Running an immunisation programme

* For details on running immunisation programmes, see Section 5 in this bibliography.

* **Morley, D.C.** (1973) Paediatric priorities in the developing world.

The chapter on measles describes how, when measles vaccination was introduced, children gained more weight.

2.2.3. Promotion of food supply and income earning activities

2.2.3.1. Increasing crop production

For agricultural extension evaluation see Section 2.3. For agricultural education teaching resources see Section 2.4.

* Arole, R. and Arole, M. (1977) JAMKHED: Comprehensive health care and agricultural development. Slide set and script. Includes a description of the farmers' clubs in India. A cassette tape is also available.

* Balldin, B., Hart, R., Huenges, R. and Versluys, Z. (1981) Child health: a manual for medical assistants and other rural health workers. Chapter 5, Section 5.5: The authors ask why is it that children do not get enough food? The answer is that one or more of these is needed:

- (1) good agriculture (land, rain, harvest, storage).
- (2) good economy (social production e.g. the ujamaa villages of Tanzania and distribution, and other resources e.g. education, job opportunities).
- (3) a healthy environment (safe/enough water, fuel for cooking, use of latrines, vector control).
- (4) good education (knowledge, attitudes to vulnerable groups) for children and mothers.
- (5) healthy social/family life (size, presence of parents-one or both, the support of each member).
- (6) prevention and control of diseases (infectious diseases, chronic illnesses).

Where these six factors are lacking there are inevitably protein-energy malnutrition, diarrhoea, infection and death.

* Chapman, G.P. and Dowler, E. (?1980) The green revolution game.

A game for 12-24 participants, in pairs. Each pair represents a farmer with a certain size of family and a certain size land. The challenge is to find ways of feeding the family before the next monsoon.

Defa Trickfilm Studios (1974) Food for health. Film, 8 mins, colour, animated cartoon. Eng. Fr. G.

An ABC of nutrition, "Food for health" explains the basic facts of good nutrition. It shows what makes up a proper diet, the danger of overeating, the importance of the various food groups, the need for cleanliness, etc. The film also shows how health education can help improve food habits but stresses that hunger and malnutrition will be solved only by better food production and distribution.

Education Development International (1973) Resources survey. Agricultural and extension work: aids to teaching and training. October: pp.161-165. A useful list of sources.

- * **International Children's Centre** (1979) Improving nutrition, what is required? Children in the Tropics No. 121. Includes small farms and marketing.

- * **Oxfam** (?1980) Keeping poultry, a game about poultry keeping in a developing country.
 "Keeping poultry" aims to give an understanding of the difficulties of a farmer in a village in the poor world by getting the players to make everyday decisions on buying, housing and feeding chicks, so that they feel the frustrations when things go wrong, e.g. what it is like to suffer an outbreak of fowlpest or have all the eggs broken on the way to the market. The costs and benefits of different decisions are based on data from Zaire (1972). The game comes with an attractive folder or record sheets, "chance cards" (good luck and bad luck), and "village income cards" (some villagers have no land).

- * **Reading Rural Development Communications Bulletin** (monthly) Newsletter.
 The issue for April 1982 concentrates on evaluation.

- * **Soucie, E.A.** (1978) Tropical horticulture for secondary schools. Book I.
 Includes choosing the site, starting the plants, field culture.

- * **UNESCO, Regional Office for Education in Asia and Oceania** (?1978) Skills of growing vegetables at home. Self learning and instructional modules in science. 64pp. Illustrated.

- UNICEF** (1977) Teaching guide for integrating nutrition in elementary school subjects. Grades I-V. Also: Elementary agriculture.

- * **UNICEF** (1982) The UNICEF home gardens handbook (for people promoting mixed gardening in the humid tropics). 55pp. Illustrated.

- US, Department of Agriculture** (1971) Homemaking handbook for village workers in many countries. 237pp.
 Home gardens: pp.66-74. Rabbit raising: pp.87-90.

- * **Wallis, H.** (no date) Learning how to grow, store and distribute food, written for Associated Country Women of the World (ACWW). Book 3, Series 2.
 The section on food production and storage includes: What to grow? (legumes, vegetables, fruits, roots), Where to grow? (a small flat plot is preferred to large slope), How to grow? (prepare the plot, rotate crops). It goes on to illustrate planting, tending, harvesting and storage. Useful.

COMPOST MAKING

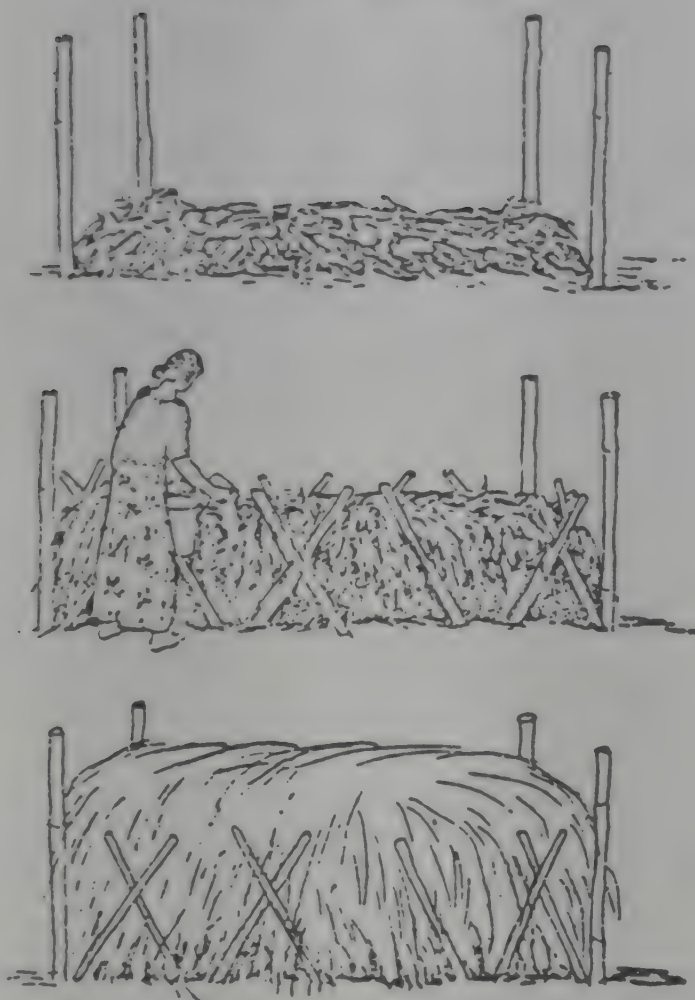


Fig. 2.19: Diagram taken from an earlier edition.

* Werner, D. (1977) Where there is no doctor.
Possible ways to work toward better nutrition: family gardens, contour ditches, rotation of crops, irrigation of land, fish breeding, bee keeping, composting, better food storage, smaller families: pp.W13, W14.

MORE WAYS TO WORK TOWARD BETTER NUTRITION

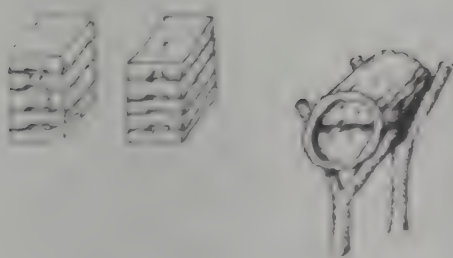
IRRIGATION OF LAND



FISH BREEDING



BEEKEEPING



NATURAL FERTILIZERS



Compost pile

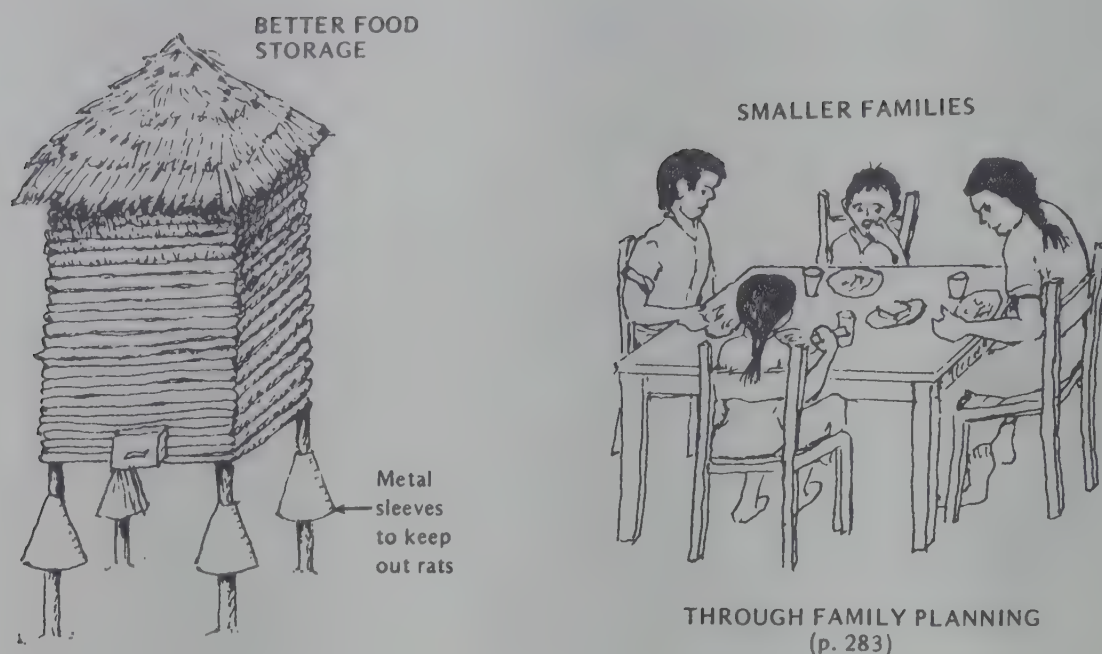


Fig. 2.20.

World Bank (1977) A system for monitoring and evaluating agricultural extension projects. Staff Working Paper No.272. 115pp.
Reference material.

* **World Council of Churches and Teldokfilms (1976)** Seeds of health. Film. Eng. Sp. Fr. G. soundtracks.
A film of the Chimaltenago Development Project, Guatemala, where health promoters were also doing agricultural extension work.

2.2.3.2.

Food storage to reduce post harvest loss

Federal Extension Service (FES AID) with US AID (1965) Storing food at home. Sanitation series No.7.
Illustrates how to store food at home: dairy foods, fresh meat, fish, poultry, vegetables. The pamphlet further explains why foods are spoilt. The author also shows ways to keep food cool, including an iceless refrigerator.

* **FAO (1974)** Rural home techniques: Food preservation, Vol.5. Series 2. Eng. Fr. Sp.
A folder containing well illustrated examples of food storage methods. Covers many processes such as drying, salting (dry), pickling, blanching, earth cover, straw cover and other methods. Excellent.

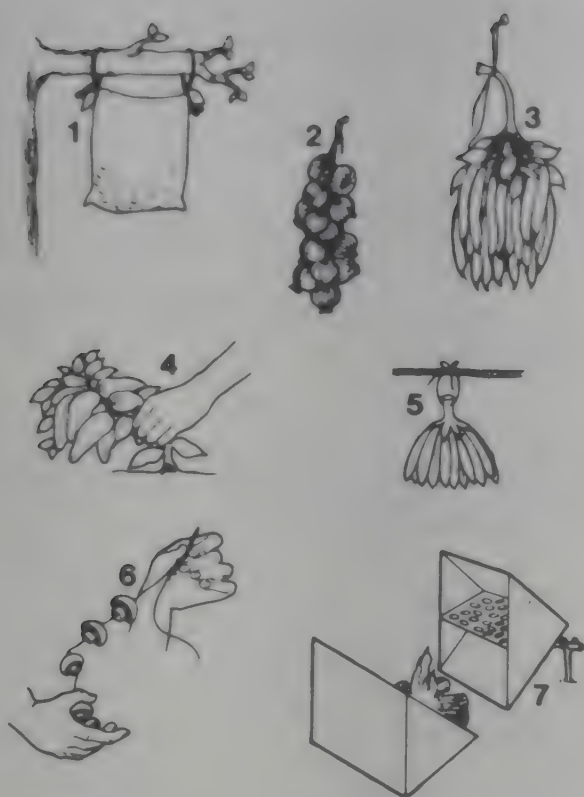


Fig. 2.21: Drying 1.



Fig. 2.22: Drying 2.

IPPF (1979) Keeping the corn on the cob. People 6 (1): p.40.

Shows rat guards and good ventilation as simple improvements to common storage methods.

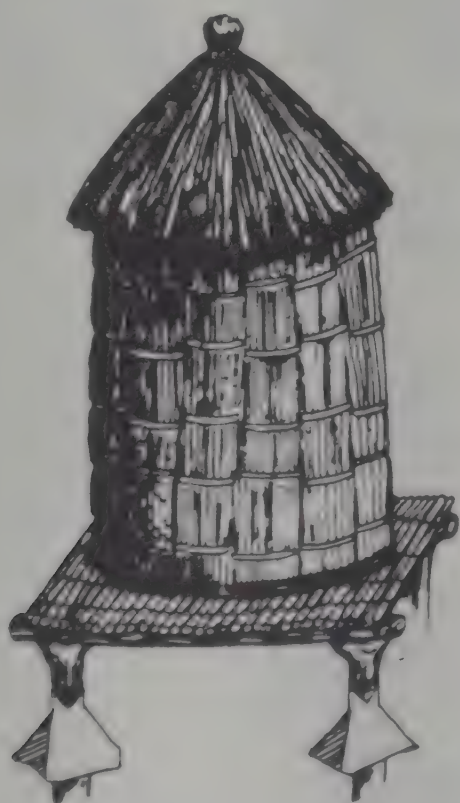


Fig. 2.23: Rat guards and good ventilation are simple storage improvements.

* Wallis, H. (no date) Learning how to grow, store and distribute food, written for Associated Country Women of the World (ACWW). Book 3, Series 2.
See the section on food storage.

* Wilson, T. and Crane, A. (?1982) Careful storage of yams.

Some basic principles to reduce losses.
A pictorial booklet illustrating the principles of improving traditional storage.

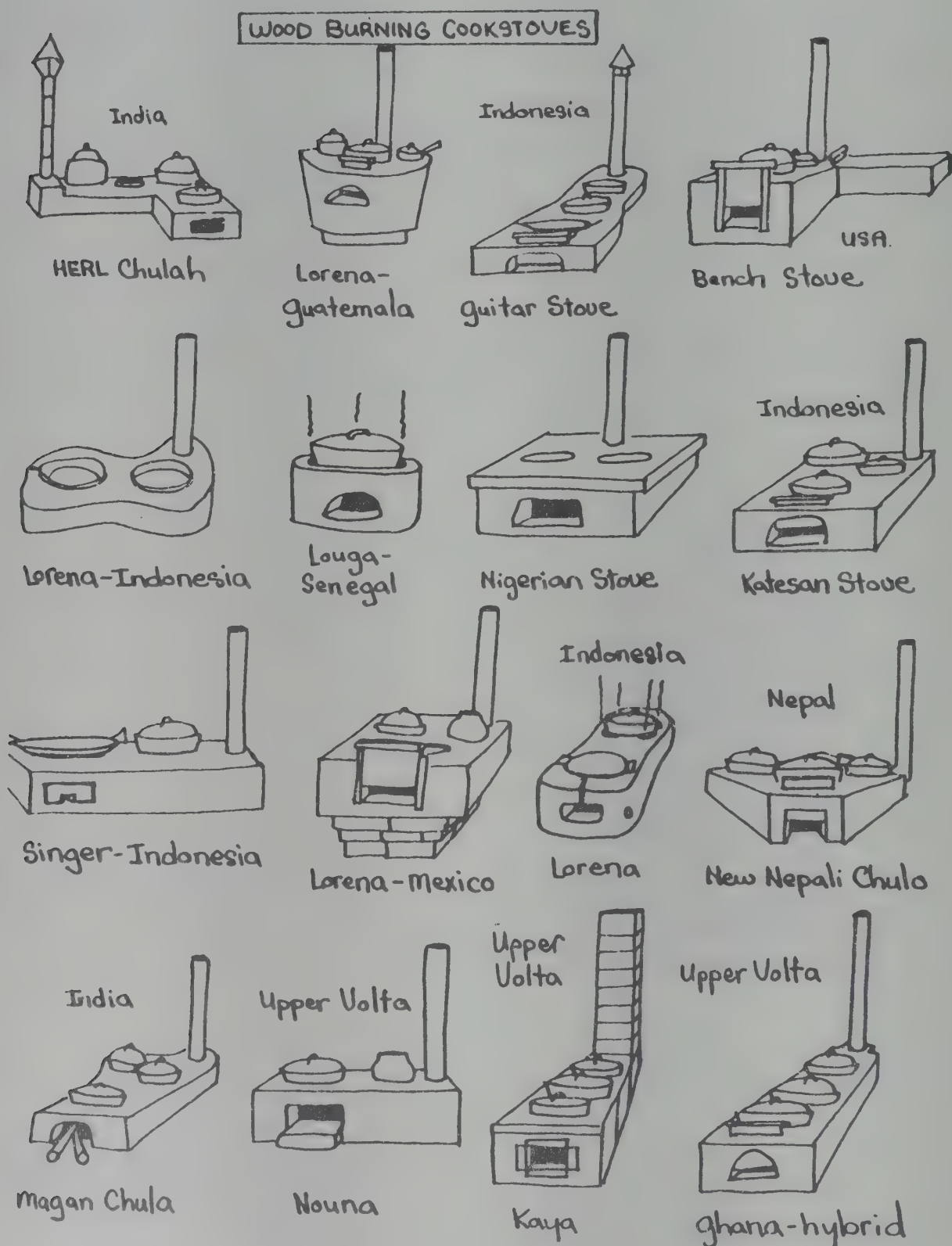
2.2.3.3.

Improving the availability of fuel for cooking

* **Boiling Point** (3 times a year) Newsletter on new cookstove technology in developing countries.

* **Cookstove News** (?quarterly).

Describes how a well built stove can reduce wood use by at least 50%. Includes examples from developing countries e.g. Niger, New Delhi, Lesotho, etc.



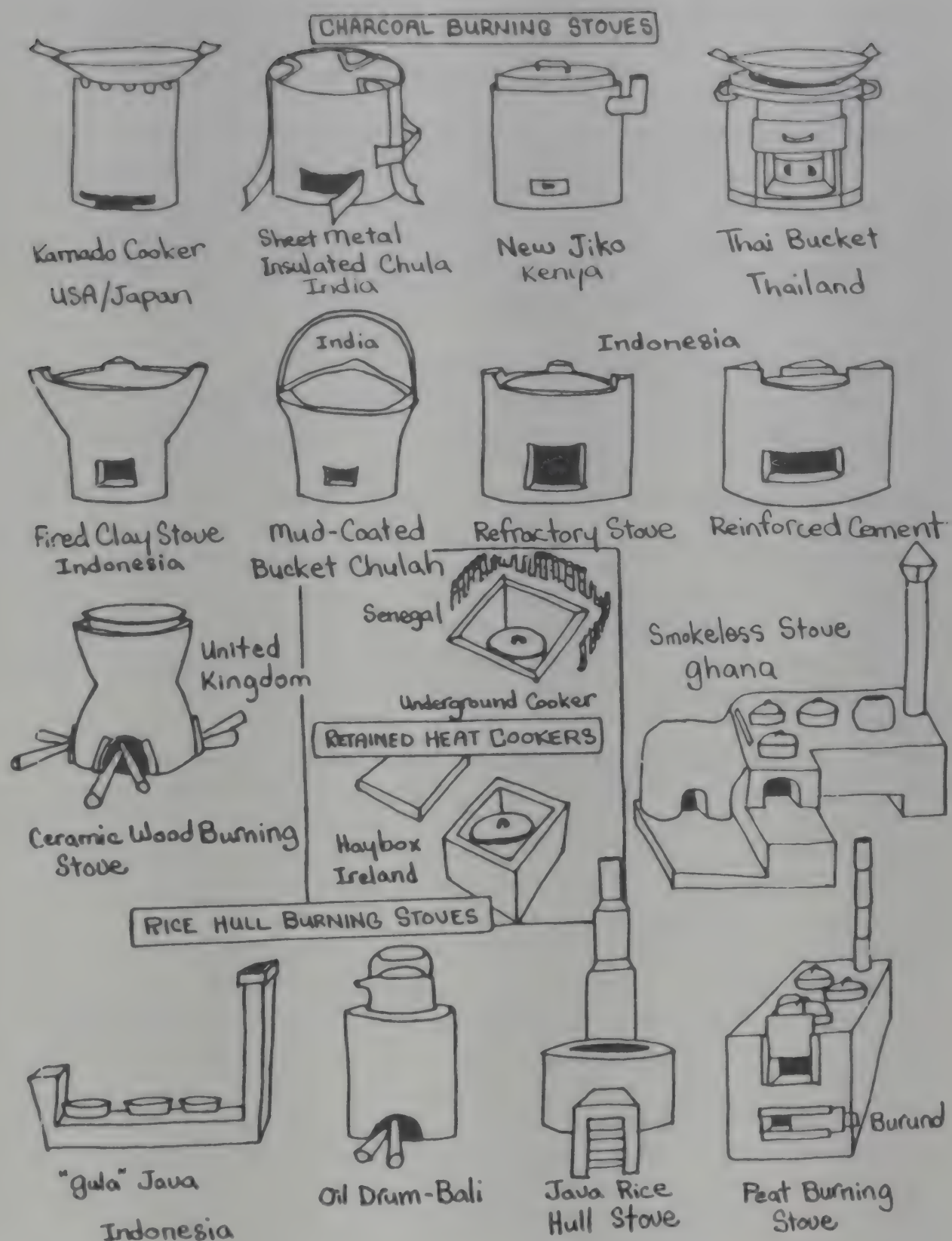


Fig. 2.24: Cookstove News (1981) 1 (1). More specific illustrations and details of building techniques are available on request.

* FAO (1974) Rural home techniques: Food preparation - cookers, cleaning and storage. Eng. Sp. Fr. Well illustrated.

Morley, D.C. et al (1971) Feeding children in West Africa. A slide set which includes examples of simple good stoves made from mud, and gives an example of making better use of wood by building a simple chimney. 48 slides and script. A cassette tape is also available.

Smith, N. (1981) Wood: An ancient fuel with a new function. Worldwatch paper 42.

The decrease in wood stocks is eroding nutrition by reducing the amount of time available to raise crops and prepare meals, because people have to spend more time looking for fuel.

USAID, Bureau for Program Coordination (1980)

The socioeconomic context of fuelwood use in small rural communities. AID Special Evaluation Study No.1. 292pp.

Covers firewood, charcoal, community fuelwood programmes. Useful questions are raised on the aim of such programmes and the type of fuelwood programme needed.

US, National Academy of Science (1980) Fire crops: shrub and tree species for energy production. 237pp.

Describes trees and shrubs which seem appropriate for areas of extreme fuel shortage. These species are fast growing and aggressive so may be useful where climates and soil conditions are harsh. Warning: In more equable environments and where no fuelwood shortages exist, such potentially invasive plants should be introduced only with great care. There is a great risk that they will spread so quickly that they will become like weeds. In any trials of fuelwood plantations it is essential that local species should be given first priority.

* **(VITA) and Intermediate Technology Development Group (ITDG) (1980)** Wood conserving cookstoves, a design guide. 90pp. Eng. Fr. Sp. Arabic.

2.2.3.4.

Income generating activities

Gana, J.M.S. (1982) How women can start an income producing project. In NFE/WID Exchange Asia 2 (6): pp.5-6.

Raises six questions: What project do you anticipate enjoying most?; Do you have the production skills required?; Do you have skills to manage your project?; Do you have the time needed?; Do you have the resources needed to set up and maintain the project?; Do you have the emotional and decision making skills needed to run an income generating project?

Gordon, G. (In press) Dawadawa power, nutrition in the Savannah of West Africa.

Includes a section on the effect of women's income earning activities on children's nutrition.

* **Newsletter, NFE/WID Exchange Asia.** (quarterly) Nonformal education/women in development, network exchange of information based at the University of Philippines at Los Banos. (UPLB)

* **University of the Philippines at Los Banos (UPLB)** Occasional papers (e.g. 1982) Patubig Homemakers' Club, textile scrap sewing project, by Panganiban, L.Q. Occasional paper No.6. 12pp.

2.2.4.

Special care for child nutrition at vulnerable times

2.2.4.1.

Nutrition before pregnancy

* Mortimer, P. (1984) Getting fit for a baby.

Wynn, M. and Wynn, A. (1981) The prevention of handicap of early pregnancy origin. Some evidence for the value of good health before conception. 68pp.

Gathers evidence to suggest that low pregnancy weight of the mother may be associated with later handicap. Suggests nutrition in the 3-4 months before conception is very important for avoiding handicap. A very important book.

2.2.4.2. Nutrition during pregnancy

See Section 1 on Maternal care.

2.2.4.3. Breastfeeding

Brewster, D.P. (1979) You can breastfeed your baby - even in special situations. 600pp.

Draws on the experiences of more than 500 nursing mothers to give reassurance that breastfeeding can continue even when there are problems. Includes case studies of the problems of breastfeeding twins, triplets, pre-term babies, during illnesses, after Caesarean section, etc. Deals with questions such as: What about travelling? How do I express and store milk for emergency use? Is milk flow affected by stress? etc. Focussed towards the USA.

Cameron, M. and Hofvander, Y. (1983) Manual on feeding infants and young children. 3rd edition.

Chapters 11 and 12: Breastmilk and its value; Management of breastfeeding.

Caribbean Food and Nutrition Institute, Jamaica (1979)
Breastfeeding, before and after.

A brochure written to encourage mothers to breastfeed. Photographs show mothers breastfeeding, and foods to be given after six months together with details of how they are prepared in the Caribbean.

Caribbean Food and Nutrition Institute, Jamaica (no date)
Breastfeeding your baby.

A slide set with commentary and teaching notes, poster, fact sheets. A cassette tape is also available. Useful.

Cutting, W.A.M. et al. (1979) Breastfeeding.

A set of 24 slides and text. A cassette tape is also available. Topics include: Why is breastfeeding best?; Physiology of breastfeeding; How to breastfeed; The social background to breastfeeding; Some common problems of breastfeeding; Breastfeeding in the second year; Nutrition of the mother; Seven reasons why breastfeeding is best.

Ebrahim, G.J. (1978) Breastfeeding - the biological option. Scientific evidence for the value of breastmilk.

* Gordon, G. (In press) Dawadawa power - nutrition in the

Savannah of West Africa.

The chapter on breastfeeding emphasises ways that mothers in rural areas can cope with problems: e.g. not enough milk in the first three months; flat nipples; breast abscess. There is a useful section on maintaining breastfeeding in different working situations.

* Helsing, E. and Savage King, F. (1982) Breastfeeding in practice, a manual for health workers.

Written to help health workers help mothers. Deals with the normal problems of establishing and maintaining breastfeeding in the first months: "the milk dried up"; "too thin milk", "the baby cries too much", the "good and quiet but non-gaining child", "I always feel tired and anxious", "the baby refused to suck", "what food should a lactating woman eat?". Also deals with special cases of breastfeeding and special problems including: relactation and induced lactation; the breastfeeding of twins /triplets; a new pregnancy during lactation; infants with a family history of allergy; mentally handicapped infants; a baby with a cleft lip or palate; low birth weight babies. Also includes useful sections about what to do if the infant or the mother is ill. The question of breastfeeding in relation to medication is covered in outline. There is an interesting chapter on malpractices and superstitions, and a helpful section on problems and 'malpractices' in maternity wards with suggestions for improvements. There is also a chapter on working and breastfeeding: "Breastfeeding mothers have always worked, breastfeeding mothers are still working". An appendix lists some of the optional organisations for breastfeeding.

Hey, E. (1980) Successful breastfeeding - a good start.

A pamphlet for mothers in Newcastle upon Tyne, UK. A case study film on successful breastfeeding is also available for teaching medical students and midwives.

India, National Institute of Nutrition (no date) Breastfeeding. Folder No.4.

* International Children's Centre (1979) Breastfeeding. Eng. Fr. Sp. Arabic, other languages.

Material prepared for the mass media, academic workers, health personnel and policy makers.

Jelliffe, D.B. and Jelliffe, E.P. (1978) Human milk in the modern world.

Many aspects of breastmilk are covered, including recent scientific evidence showing the advantages of breastfeeding: anti-allergic, anti-infective, metabolic uniqueness, emotional rewards, contraceptive effects, etc.

* Kenya, Breastfeeding information group newsletter.

Kitzinger, S. (1979) The experience of breastfeeding. Written for mothers in the UK.

La Leche League International Inc. (no date) Mother to mother support for breastfeeding.

For other countries see Helsing, F and Savage King, F. (1982) Breastfeeding in practice.

National Childbirth Trust, UK (1969) Easy breastfeeding.

A leaflet written for UK mothers, showing how to prepare for breastfeeding during pregnancy, what to do to start breastfeeding (first feeds, night feeds) and what to do for engorged nipples, sore nipples or insufficient milk. The National Childbirth Trust is a mother to mother support organisation in the UK. For other countries see Helsing, E. and Savage King F. (1982) Breastfeeding in practice.

* **Raphael, D. (1981) Breastfeeding, the tender gift (Also: Breastfeeding and food policy in the modern world).**

A series of papers on breastfeeding in different countries. Expensive and lengthy but useful for anyone wanting to see the relevant paper for a particular country. Useful too in its explanations of methods for finding out about breastfeeding practices from an anthropological point of view, i.e. how to find out why women do what they do. It is also useful in recognising that most writing on infant feeding is either pro breastmilk or pro formula milk rather than about how to cope with feeding a hungry baby and also do all the other things women have to do.

* **Susu Mamas.** Breastfeeding newsletter from Papua New Guinea.

* **Werner, D. (1977) Where there is no doctor.**

How a mother can produce more milk: drink plenty of liquids, eat as well as possible, get plenty of sleep and avoid getting very tired or upset, nurse the baby more often: p.271. Bottled babies are more likely to get sick and die, breastfed babies are healthier.

* **WHO (1979) Breastfeeding. Booklet. Eng. Fr. Sp. Port. Arabic.**

Simple and straight-forward, illustrated information on breastfeeding.

WHO, Regional Office for the Americas (no date) La lactancia materna: Filmstrip No.68

Useful to show how to express milk: visuals 16-18. Includes fairly good illustrations of mothers feeding babies but it is difficult to follow unless the story is explained. A bottle appears in one visual and not again: two brassieres appear, one with an enormous X. Only expressing milk is illustrated clearly.

Zimbabwe (1981) Baby feeding - behind and towards a health model for Zimbabwe. 62pp.

Colour pictures and photographs depicting the importance of breastfeeding. Includes reports from the WHO and UNICEF Code of Ethics on infant formula sales and advertisements. Sets out Zimbabwe's own commitment to promoting breastfeeding in the future.

2.2.4.4.

Weaning

Barnabas, G. (1982) Preventing malnutrition, and nutrients in our food. Tigrinya only.

- * **Cameron, M. and Hofvander, Y.** (1983) Manual on feeding infants and young children. 3rd. edition.
Special reference is made to homemade weaning foods.

- * **Ebrahim, G.J.** (1980) Practical mother and child health in developing countries.

- * **Ghosh, S.** (1976) The feeding and care of infants and young children.
Based on the 1971 edition of Cameron and Hofvander, manual, and much improved to help understanding. Emphasises local weaning foods.

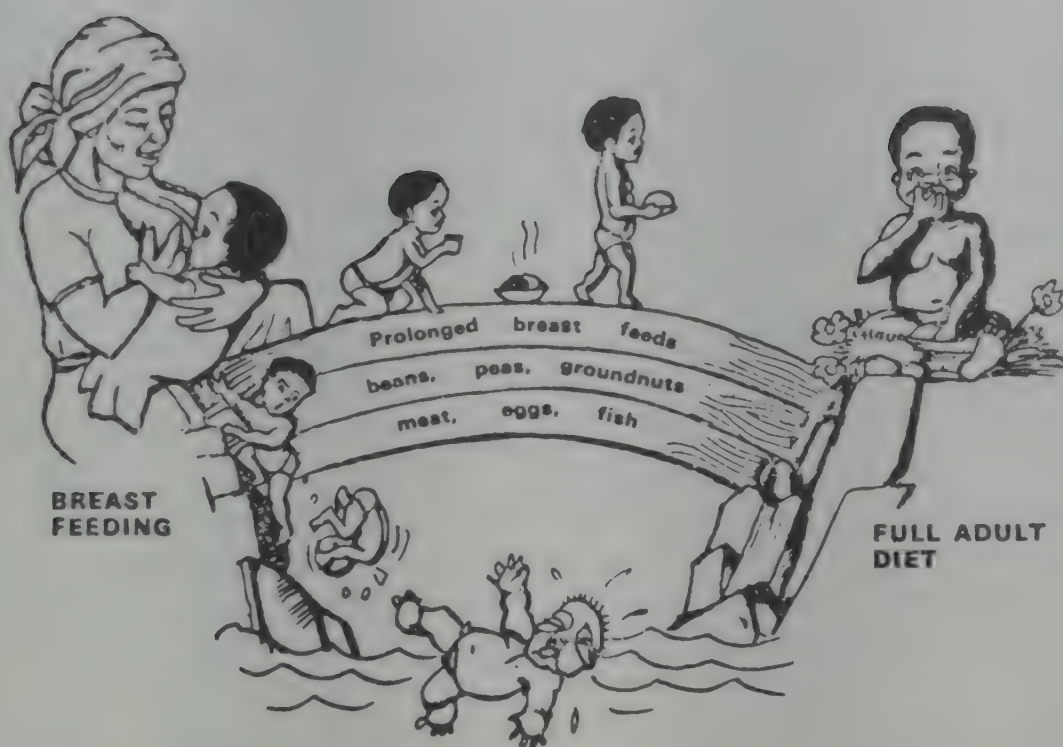
- * **Gordon, G. and Gordon, S.** (1981) Nutrition and child health flannelgraphs.
These flannelgraphs and scripts cover 7 topics: Using flannelgraphs to communicate ideas in nutrition and health; Come to the child welfare clinic; Measles; Learning to eat; Give your child plenty of soup; Feed your child 3 times a day; Diarrhoea - prevention and home management. Designed for the Savannah of West Africa. The script is well illustrated, and the flannelgraphs well designed for mothers.
Learning to eat covers the problems of weaning, and the basic rules for good child feeding, which are enlarged in: Feed your child 3 times a day, and Give your child plenty of soup.
The objectives of these sections are to help (parents) mothers: to know the importance of breastfeeding for the first two years; to introduce additional foods at 4 months of age; to know that children need frequent feeding because of their small stomachs and great need to grow. They should also know that a child needs plenty of soup with the staple food, and to be aware of the value of body building (protein), protective (vitamins and minerals) and high energy supplements in the diet so that they can increase their cooking skills in combination of various locally available foods.

- * **Helsing, E. and Savage King, F.** (1982) Breastfeeding in practice; a manual for health workers.
Chapter 9: Not by mother's milk alone - supplementation and weaning.

- * **King, M., King, F., Morley, D., Burgess, L. and Burgess, H.** (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa.
Chapter 7 discusses what, when and how often children should be fed, including a description of the first 'solid' food - porridge. It also considers the question of how a working mother can feed her young children.

- * **Morley, D.C. and Harman, P.** (1979) The third world: What the child eats and how this has changed our approach to malnutrition. Nursing Times 75: pp.1881-1883.
Emphasises the need for high energy foods which are not too bulky, for small children. Their stomachs are so small that they would need to eat a mound of rice almost the same size as themselves to get enough calories. The addition of oil provides energy without too much bulk.

The three planked protein bridge crossing from breastfeeding to an adult diet. Source: TCHU. This picture may be reproduced.



The three-planked bridge that crosses the dangerous years from breast milk to adult diet.

Fig. 2.25.

During the transition from breastfeeding to an adult diet, three types of protein foods are used: prolonged breastfeeding; beans, peas and groundnuts; and meat, eggs and fish.

Uganda, Ministry of Health, Health Education Division (1973)
Body building food. 15pp.
A useful locally produced document.

2.2.4.5. Care of the malnourished child

Barnabas, G. (1982) Management of malnutrition, Book 2, and Nutrition Education, Book 3. Tigrinya.
These booklets, written for use in health work in rural Eritrea and Tigray (Ethiopia), describe the local staples and their nutrition values. The mixing of various staples with legumes and the addition of the oil seeds abundant in the country is emphasised with simple illustrations. Particular attention is paid to promoting breastfeeding and to starting initial foods early. By custom, the people tend to introduce their babies to solid food very late.

Cutting, W.A.M. (1976) Nutrition rehabilitation: principles of nutrition rehabilitation, with illustrations from India.
A set of 24 slides with explanatory text. A cassette tape is also available. The NRU - nutrition rehabilitation unit is conceived as a place where workers learn and possibly teach each other cooking, feeding, playing, gardening and homecraft. Since the NRU

will have a limited capacity, the lessons learnt are expected to be spread when the workers involved go back to the community.

Firebrace, J. (1981) Infant feeding in the Yemen Arab Republic.

This study examines the particularly dramatic shift of mothers from breastmilk to bottle in Yemen, the reasons why it has occurred and the measures needed to reverse it. The promotional activities of the major infant food companies operating in the Yemen are seen against the WHO/UNICEF recommendations of October 1979.

* **Goyet, de Ville de, C., Seaman, J. and Geijer, V.** (1978) The management of nutritional emergencies in large populations. This book is written for emergency nutrition management in famine, refugees, monsoon, flood, etc. It also has sections e.g. Chapter 3: Assessment and surveillance of nutritional status, which are of wider interest. There are many useful guidelines on treatment (e.g. for dehydration, infections) and anthropometric measurement standards (arm circumference, weight for height).

* **International Children's Centre (ICC)** (1981) Child malnutrition: early diagnosis, treatment and prevention. This document is in three sections: one for mass media specialists (radio, TV, press); one for nurses, social workers and teachers; and another for physicians, professionals, university level personnel. The size and scope of under-nutrition is discussed with the help of figures, tables and graphs. Treatment and intervention methods are suggested. Useful references are given at the end, with suggestions for action that could be taken by each of these three groups.

Morley, D.C. (1978) Malnutrition in India.

A set of 24 slides with a text explaining each slide. Includes: protein energy malnutrition (wasting, stunting, marasmus, kwashiorkor); vitamin A deficiency; vitamin D deficiency; vitamin B deficiency and mixed deficiencies; nutritional anaemias; weight charts. The ways to prevent malnutrition and management aspects are discussed. A cassette tape is also available.

* **Morley, D.C.** (1973) Paediatric priorities in the developing world.

Chapter 7: The road to health card.

Morley, D.C. (1979) Protein-calorie deficiency. A set of 24 slides and text. A cassette tape is also available. Shows the world wide distribution of protein-calorie deficiency, with examples from India and Africa showing the importance of growth monitoring and the effect of measles.

* **Morley, D.C. and Woodland, M.** (1979) See how they grow. Chapter 6: The weight curves of malnourished children. Contains many ideas for teaching.

NANI, National Alliance for the Nutrition of Infants c/o Voluntary Health Association of India (VHAI).

NANI includes representatives of health, consumer and development

action groups, and will design and distribute posters, leaflets and booklets on breastfeeding, aimed at the general public.

Ross Institute (1970) Protein calorie malnutrition in children. Bulletin No.12.

Shack, K.W. (ed.) (1977) Teaching nutrition in developing countries (or the joy of eating dark green vegetables).

Uganda, National Food and Nutrition Council (1973) The therapy of the severely malnourished child; a practical manual. 50pp. Closely-typed reference material.

US, Dept. Health and Human Services (1980) Weighing and measuring children. A training manual for supervisory personnel. Equipment and methods for measuring physical growth are explained, with the aid of graphs and tables.

United States Catholic Conference (USCC) (1978) Lessons in nutrition and health for mothers.

Nutrition "lessons" for mothers, organised in the form of a "course". An introductory section on hygiene, sanitation and family health precedes the sections on nutrition which deal with energy foods, growth (?protein) foods, cooking, breastfeeding, feeding at school, nutrition during pregnancy, etc. Ways of distributing food at the family level in favour of the vulnerable are discussed. The value of vegetables and milk products are stressed. The lessons are illustrated with many small drawings.

* WHO (1981) Guidelines for training community health workers in nutrition. WHO Offset Pub. No.59.
An introduction for the health worker beginning to work on nutrition in the community. The causes of undernutrition and how they can be measured in the community and monitored are discussed. The diarrhoea/infection/nutrition complex is well covered. Infant feeding is also considered.

* Zambia, National Food and Nutrition Commission (1970) Protein-calorie malnutrition.
Useful material for training teachers, illustrated with many photographs suitable for teaching village workers, e.g. depicting: six children with different types of malnutrition: p.5; the causes of protein calorie malnutrition: pp.16, 17; education of fathers: p.42; the dangers of bottlefeeding: pp.57, 58.

2.2.4.6.

General design of nutrition education programmes

* Holmes, A.C. (1968) Visual aids in nutrition education; a guide to their preparation and use.
Five elements are needed for nutrition education: diagnosing the educational level of the group, communicating effectively, understanding human behaviour, using the knowledge gained, planning and putting programmes into motion. Suggested visual aids include: a snakes and ladders game: p.42; playing cards: p.40; using a plastograph: p.40; using a strip cartoon: p.26.

* **Murthy, R.K.** (1975) Laksham kills a tiger.
A comic strip from India: a good example of material in this form.
The story demonstrates the necessity of good food in childhood.

* **Ritchie, J.A.S.** (1969) Learning better nutrition; a second study of approaches and techniques.
Includes useful photographs and amusing illustrations. There is a good description of the use of cocoon puppets and glove puppets for nutrition education in Korea: pp.128, 129.

* **Sweemer, C. et al.** (1978) Manual for child nutrition in rural India.
This book is an 'Indianised' version of the book "Nutrition for developing countries" edited by King, M. et al. The pictures, names of foods, types of foods, that appeared in the original have been changed.

US, Dept. Agriculture (1971) Homemaking handbook for village workers in many countries. 237pp.
Planning teaching content: pp.30, 31.

* **Werner, D. and Bower, B.** (1982) Helping health workers learn.
Part 1: Approaches and plans. Part 2: Learning through seeing, doing and thinking. Part 5: Health in relation to food, land and social problems.

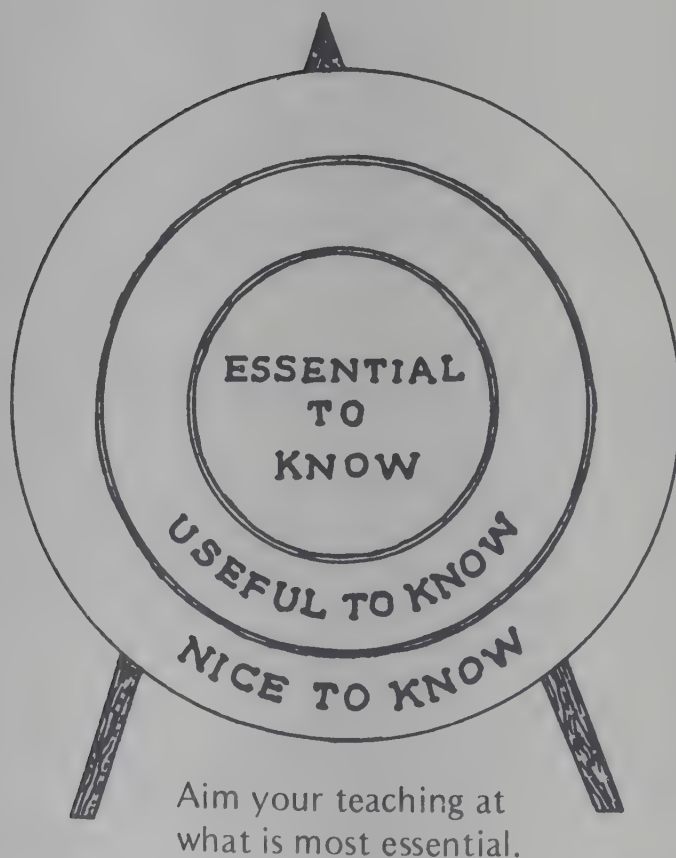


Fig. 2.26: Aiming teaching at what is most important: pp.5-10.

* **Zaire, Bureau d'etudes et de recherches pour la promotion de la sante.** Leaflets. Fr.
Comment bien se nourrir? (Brochure 21).
Education nutritionnelle (Brochure 7).
La malnutrition de l'enfant et ses consequences (Brochure 8).
Nutrition: illustration pack.
L'educateur nutritionnel (Brochure 32).

* Zambia, National Food and Nutrition Commission (no date)
Posters: Eat more groundnuts; Breastfeeding is best but you need to add food after three months; Feed your child three times a day.

2.3.

Evaluating nutrition teaching and nutrition intervention programmes

Drummond, T. (1975) Using the method of Paulo Freire in nutrition education. An experimental plan for community action in Northeast Brazil. Cornell International Monograph Series No.3.

Gwatkin, D.R., Wilcox, J.R. and Wiay, J.D. (1980)
Can health and nutrition interventions make a difference?
Overseas Development Council, Monograph No.13.
Very useful.

* Holmes, A.C. (1968) Visual aids in nutrition education; a guide to their preparation and use.
Evaluation of visual aids in nutrition education: pp.142-147.

Kehrberg, N. (1978) Good health, teacher's guide and manual.
Eng. Nepalese.
Covers: 1) Good food for the newborn; 2) Feeding a six month old child; 3) Undernutrition; 4) 'Medicine-water' for diarrhoea; 5) 'Super' porridge. Includes a useful pretest and post test.

Kielmann, A.A. et al. (no date) Evaluation of nutrition intervention projects.

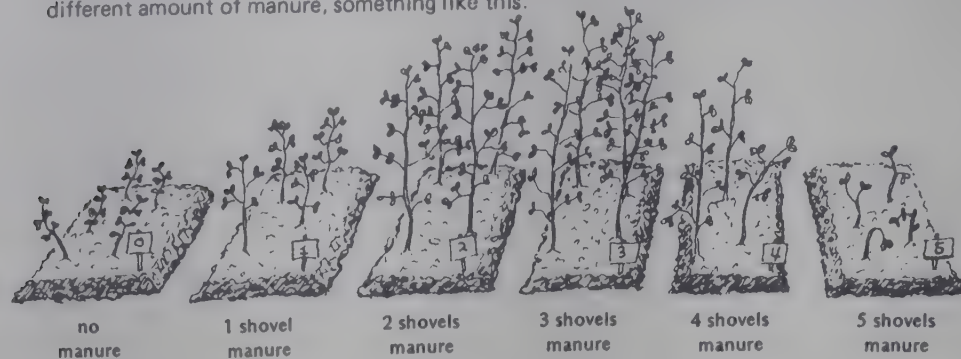
* King, M., King, F., Morley, D., Burgess, L. and Burgess, H. (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa.
Includes suggestions for things to do at the end of each chapter.

Shinkwekar, A.G., Gopaldos, T., Srinwasan, N., Bhargava, V. and Settr, D. (1977) Nutritional rehabilitation at the hut level: education impact. J. Trop. Ped. 23: p.997.

USAID Office of Nutrition (1975) A field guide for the evaluation of nutrition education.

Werner, D. (1977) Where there is no doctor.
Suggests trying a new idea (manure) to see its effects on growing crops (See Fig. 2.27. below). The experiment shows that a certain amount of manure helps, but that too much can harm plants: p.W15.

For example, to find out if animal fertilizer (manure) helps the beans grow, and how much to use, plant several small bean patches side by side, under the same conditions of water and sunlight, and using the same seed. But before you plant, mix each patch with a different amount of manure, something like this:



This experiment shows that a certain amount of manure helps, but that too much can harm the plants. This is only an example. Your experiments may give different results. Try for yourself!

Fig. 2.27.

World Bank (1977) A system for monitoring and evaluating agricultural extension projects. World Bank Staff Working Paper No. 272. 115pp.

WHO (1979) A guideline for the measurement of nutritional impact of supplementary feeding programmes aimed at vulnerable groups. FAP/79.1.

WHO (1980) Xerophthalmia surveillance. NUT/80.18.

2.4

Useful sources of nutrition teaching material

* **Education Development International** (1973) Resources survey. Agricultural and extension work: aids to teaching and training. Education Development International (October): pp.161-165.

Useful although now old.

Ethiopia, Nutrition Institute (regular) Visual aids for child care and nutrition education.

New material is issued regularly.

TALC (various dates)

Growth charts, manuals, slide sets, flannelgraphs.

United States Catholic Conference (USCC) (1978) Lessons in nutrition and health for mothers.

* **VHAI** (annual) Catalogue of low cost educational materials: nutrition pamphlets, flannelgraphs, flipcharts, etc.

WHO/UNICEF (no date) JNSP nutrition learning packages.

Produced by the joint WHO/UNICEF Nutrition Support Programme for use in training community health workers in nutrition information and how to use it in the community. The learning packages are:

- (1) Getting to know the community
- (2) Measuring growth
- (3) Breastfeeding

- (4) Young child feeding
- (5) Nutrition of mothers
- (6) Nutrition deficiencies
- (7) Nutrition in infection and diarrhoea
- (8) Communicating nutrition
- (9) Solving problems

The packages are intended to be adapted in accordance with local conditions.

- * Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (annual) Catalogue. Eng. Fr.
- * Zambia, National Food and Nutrition Commission (various dates) Posters, etc.

2.5.

Newsletters for teachers to keep up to date with nutrition and nutrition education

- * Boiling Point See details in Section 2.2.3.3.
- * Cajanus (quarterly) Caribbean Food and Nutrition Institute, P.O. Box, 140, Kingston 7, Jamaica, W.1.
- * Cookstove News (? quarterly) The Aprovecho Institute, 442 Monroe, Eugene, Oregon 97402, USA.
- * FAO (bimonthly) Ideas and Action. Freedom from hunger campaign/Action for development. Eng. FAO, Rome 00400, Italy.

Information for International Development (IFID) India c/o IDL Rural Development Trust, IDL Chemicals Ltd, P.O. Bag No. 1, Sanatnagar (IE) PO, Hyderabad 500 018, India.

IFID is interested in the production of low cost nutrition newsletters and particularly the development of nutrition strip cartoons.

- * International Nutrition Communication Service (INCS) (no date) Nutrition training manual catalogue for health professionals, trainers and field workers in developing countries. Israel, R. and Lamprey, P. (eds.) Copies available from either Ron Israel, INCS, Education Development Centre, 55 Chapel Street, Newtown, MA 02160, or Maternal Nutrition, American Public Health Association, 1015 Fifteenth St. NW, Washington DC 20005, USA.

- * Kenya, Breastfeeding information group Newsletter. P.O. Box 59436, Nairobi, Kenya.

- * League for International Food Education Newsletter. Suite 915, 915 Fifteenth St. NW, Washington, USA. Practical suggestions for nutrition education.

- * Mothers and Children Bulletin on infant feeding and maternal nutrition. (1982) 2 (1) American Public Health Association.

This is a new bulletin that deals with many aspects of child and maternal nutrition. Topics include growth monitoring (through

measurement), breastfeeding, diet in pregnancy, and lactation. Legal aspects such as maternity leave policies in the Middle East are reviewed.

* **Papua New Guinea, Department of Public Health Nutrition and Development** - a newsletter of the Nutrition Section of the Public Health Dept. P.O. Box 2084, Kenedobu, Papua New Guinea. This magazine is aimed at improving children's nutritional status through public education. Contributors include health workers, economists, anthropologists.

* **Reading Rural Development Communications Bulletin** (monthly) Newsletter. Agricultural Extension and Rural Development Centre, London Road, University of Reading, UK.

* **Susu Mamas** Breastfeeding newsletter from Papua New Guinea. Port Moresby, P.O. Box 5857, Boroko, Papua New Guinea.

* **WHO (1981) Appropriate Technology for Health Newsletter No.10.** Health education methods and materials in primary health care. Deals with a range of topics from breastfeeding to health games for children; eradication of rats; using a calendar; 'theatre' on primary health care etc. These topics were selected from local data from various countries. The pictures (line diagrams) are excellent.

* **Xerophthalmia Club Bulletin** (quarterly) Club Secretary, 31 Observatory Street, Oxford, UK.

Notes

Notes

3. Promotion of normal growth and development of children and young people.



3. Promotion of normal growth and development of children and young people.

3.1. Overview

Growth and development covers not just physical change but also emotional, social and psychosexual growth, not just in infancy and childhood but through adolescence and into adulthood. However, much of the literature covers physical growth only: there is little on adolescence and on changes such as becoming a parent, grandparent etc.

3.2. Promotion of physical growth and development

* Many of the asterisked books in Sections 3.3., 3.4. also cover promoting physical development.

* See also Section 2 of this bibliography, particularly Section 2.1. Finding out how well children are growing in the community.

APHA (American Public Health Association) (1981) Primary health care issues: growth monitoring, Series 1 No.3. A review of experiences and methods of growth monitoring at the community level, all over the world, particularly in developing countries. The emphasis is on the anthropometric measurements of children: weight for age, height for age, weight for height, and arm circumference. Problems related to finding an acceptable definition of what constitutes adequate growth are discussed (comparing the Boston or Havard Standard, Tanner's reference population, NCHS National Academy of Science's reference population). Different weight charts (e.g. Road to Health, WHO growth charts) are discussed. Considers the weighing scales recommended by various authorities, with reference to their cost, ease of use and the possibility of local production.

* Balldin, B., Hart, R., Huenges, R. and Versluys, Z. (1981) Child health; a manual for medical assistants and other rural health workers. Chapter 2: Normal growth and development. An introduction to the concepts of growth (increase in size) and development (physical and emotional). The growth of the child starts before birth, and this book stresses the factors that enhance and/or hamper growth during pregnancy (foetal growth). Development is discussed in the light of nutrition, emotional support, play etc. The milestones in child growth and development are explained.

Cameron, M. and Hofvander. (1983) Manual on feeding infants and young children. 3rd edition.

Chapter 1: Growth and development of the young child. "When a child is born it is already nine months old". A child must have had adequate growth before birth in order to grow and develop further after birth. The recommended intakes of energy, protein, vitamins and minerals during pregnancy are stated. Environmental

factors which affect the growth and development of young children are described.

* **Chauvin, R. and Dupin, H.** (1971) *Hygiene et dietitique infantiles, de la naissance a deux ans.* Fr. 3rd edition. Accounts of pregnancy, birth, child development, hygiene and vaccines are well presented, and illustrated with many good shaded figures of sub-Saharan African women and children.

* **CHILD-to-child Programme** (1979) *Playing with younger children.* Leaflet. Eng. Fr. Sp. Port. Arabic. Children everywhere spend some time looking after their younger brothers and sisters, and this is one of the most important ways in which they help in a family. Children will often be told what not to do when looking after baby - "Don't let her near the fire. Don't let her hurt herself." But they are seldom told what to do. Yet if a baby is not played with she may grow up not being able to learn properly. This leaflet is to help older children learn how to play with younger children so that babies will grow up bright and alert.

Whoever introduces these ideas to older children needs to explain why children need play as well as how play can be organised. They need to explain the ideas to parents and help gain community support, particularly when older children help with play groups and child-minding groups. Many different people and means can be used to introduce the activity: schools and school teachers; health workers at clinics and in homes; youth leaders, and even the press and radio.

A very useful leaflet containing many practical ideas.

* **CHILD-to-child Programme** (1979) *Toys and games for young children.* Leaflet. Eng. Fr. Sp. Port. Arabic. This very useful leaflet discusses how older children can play with their younger brothers and sisters, where they can find materials, what to make and how to make it. It is packed with ideas.

* **Cohen, S.J.** (1976) *Childhood development: milestones in the first year.*

A set of 24 slides with text. A cassette tape is also available. Milestones in childhood development are arbitrary in that growth is a process, a continuum, but there are stages, and the better known ones in the first year of life are explained in these slides.

Ebrahim, G.J. (1982) *Child health in a changing environment.* Chapters 1 and 2 deal with the pre-natal, early post-natal, young infant and older child's growth and development. In Chapter 1, the current state of knowledge on foetal growth and the role of the environment are reviewed. Maternal childhood experiences in health and nutrition determine the biological environment of the foetus long before conception. At a later period the child is likely to falter in growth if the family size is big and if there was a failure of mother-infant bonding due to the absence of contact in the early 'critical period'. This is apart from the established factors such as food, shelter, clothing and protection. A risk approach which aims to promote the adequate growth and development of children physically, emotionally and

intellectually is suggested. In Chapter 2, the growth and development of young infants and older children are discussed. Growth denotes increase in size which may be due to increase in the size or number of cells. Development, however, is functional. Growth is not linear or continuous, rather it is uneven with rapid and slow processes acting together. One organ (e.g. lymphoid tissue) may grow quickly while another (e.g. muscle) grows fairly steadily. It is possible to identify critical (sensitive) periods of growth (e.g. puberty) which can be influenced by adverse conditions. On the other hand, there are individual biological differences which mean that some children 'mature' early and others late. There is also catch-up growth whereby children experience an increased velocity of growth, given better conditions. Monitoring the growth of children through simple measurements (growth charts, measurement of arm circumference) is explained. The improvement of environmental determinants, in which nutrition is a major factor, is discussed, quoting actual and historical experiences (e.g. famine). The psycho-social dimension of growth is reviewed.

* FAO (1975) Child care. A handbook for village workers and leaders.



FIRST MILESTONE



FOURTH MILESTONE



SECOND MILESTONE



FIFTH MILESTONE



THIRD MILESTONE



SIXTH MILESTONE

SEVENTH MILESTONE



EIGHTH MILESTONE



Fig. 3.1: Development milestones in young children: p.24.

Graves Medical Audiovisual Library, UK (Various dates) Tape slide sets for sale (or hire in UK only). Some videocassettes are also available.

The library contains many useful programmes on the growth and development of children.

See items listed under Sheridan, M. in this bibliography.

Gregory, M., Ranger, A., and Butler, K. (1978) Deafness in children. 20 mins. Cassette tape. Produced as a study block project by three third year student nurses. Considers the importance of sound in the development of the child.

Griffiths, M.J. (1980) Developmental screening.

A set of 48 slides divided into two parts:

Part one (1-24 slides): the first year of life.

Part two (25-48): the second year of life.

The text and slides are aimed at public health nurses and non-specialist doctors, and other professionals who are regularly responsible for screening children. A cassette tape is also available.

* Head, J. and Mogford, K. (1972) Nottingham University Toy Library for handicapped children. Slide set. Establishes the concept of a library of toys which the parents of handicapped children can borrow. Explains the different categories of toys required for different purposes, ages, handicaps; and the service provided by the library. The slides are intended for the community health service, child care workers, health visitors, social workers and occupational therapists.

* Health Education Council, UK (no date) Hello baby! Leaflet.

* Health Education Council, UK (no date) Play and things to play with. Leaflet.

* Health Education Council, UK. (no date) Your children need

you (to listen to them, to talk to them, to watch them, to care for them, to learn from you). Leaflet.

* Helander, E., Mendis, P. and Nelson, G. (1980) Training the disabled in the community, an experimental manual on rehabilitation and disability prevention for developing countries. DRP/80.1. Rev 2.

An excellent detailed guide to help children (and others) with problems with hearing, learning, moving, or seeing, and those who have fits or show strange behaviour.

Outlines how children usually grow, up to the time of going to school (see illustrations), and then outlines play activities to help the child do the next activity. The play suggestions are coded with small pictures relating to the normal pattern of development.

HOW CHILDREN DEVELOP

Children usually grow up following this pattern of development:



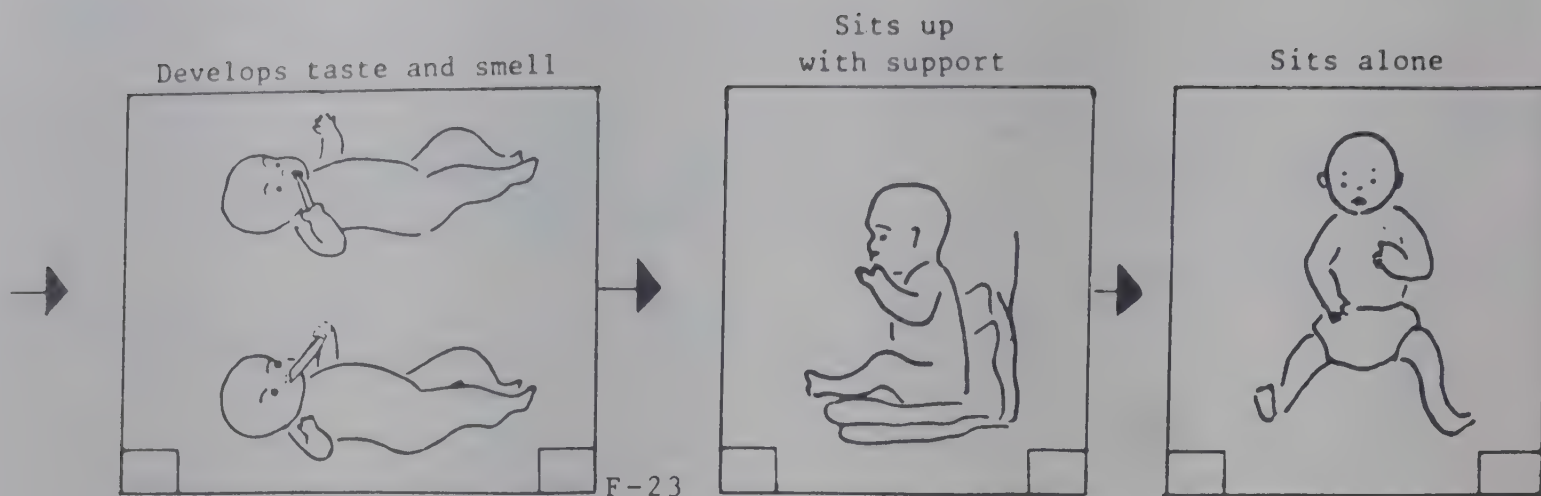


Fig. 3.2

PLAY ACTIVITIES



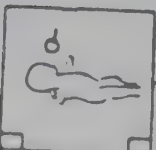
- Place the child on his/her stomach.

Hold a brightly coloured cloth, tin or toy in front of the child and move it up so that he/she will lift the head up to look at it.

Hold it, then show it again.

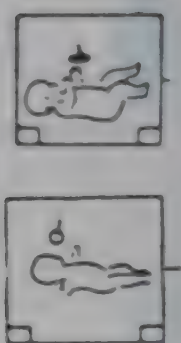


- Still with the child lying on his/her stomach, clap your hands above the child's head to make him/her lift the head to look up.



- Make toys with brightly coloured tins which make a noise when they move. Hang these so that the child can see them, hear them and touch them when they are moved.





- Hang bits of brightly coloured cloth on a string. Blow at them so that the child can watch their movements.



Fig. 3.3.

* Illingworth, R.S. (1981) Your child's development in the first five years.

Chapter 3: How should he develop physically?

Includes: Why is he not growing properly?; Why is he getting fat?; The prevention of infection.

* Illingworth, R.S. (?1975) Your child 5-12 years. Booklet.

* Linard, P., Publishing (1977) Leaflet series: How I grow - first nine months; 10 to 18 months. How much I need to do myself and how I think - 18 months to 3 years. I can do things - 3 to 5 years.

Marshall, W.A. (1977) Growth.

A set of 24 slides with text, addressed to senior health workers. Such concepts as distance curve and velocity curve are explained, and the use of centiles, skinfold measurements, and the age at which puberty is reached. A cassette tape is also available.

* Morley, D.C., Lovel, H.J., and Savage, F. (1978) Charting growth.

A set of 24 slides with text. A cassette tape is also available. Describes the "Road to health" chart developed in the 1950's by one of the authors. Slides 1-22 are for everyone and 23-24 are for teachers. The text also includes 4 appendices with drawings: (1) the meaning of the upper and lower lines on the "Road to health" chart; (2) a local events calendar; (3) brain growth; and (4) two exercises on the use of the weight chart.

* Morley, D. and Woodland, M. (1979) See how they grow.

This book pays special attention to child development and ways in which this can be measured effectively in populations and in rural areas. Malnutrition being the most important factor in the ill-health in children of developing countries, how can it be prevented? (child nutrition, health care services). What other factors are related to malnutrition? (infections). Who should be responsible for the overall development of a community and the 'health' of its members? (children, mothers, community involvement.) A comprehensive approach to the issue of undernutrition in children of the third world and its effect on child development. pp. 218-223: Measuring motor development and talking, on a weight chart.

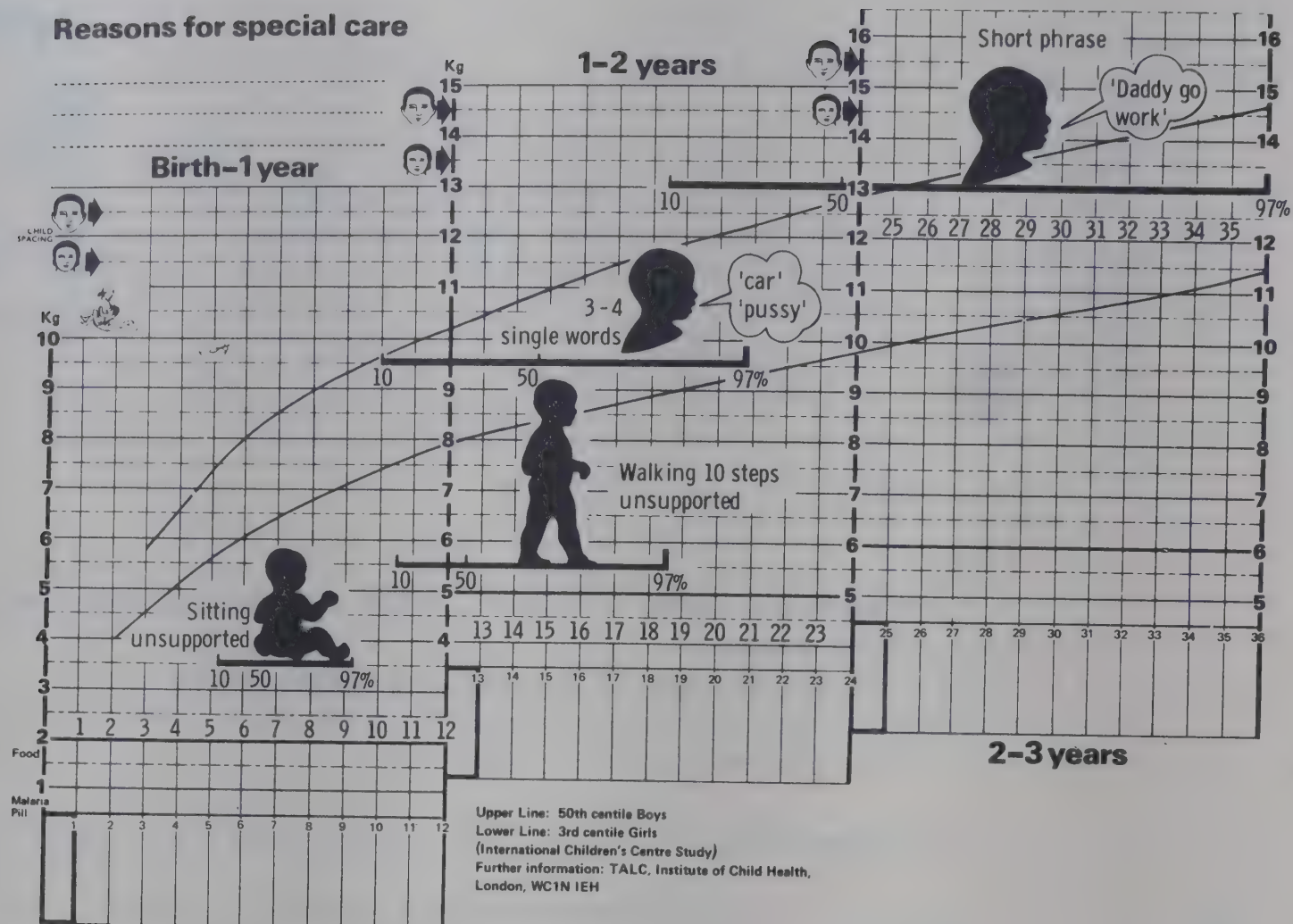


Fig. 3.4: The age at which children sit up, walk ten steps unsupported, say three to four words and short sentences, with the centile variations when these are achieved.

* Morley, D.C. (1969) Flannelgraph of the growth chart. The flannelgraph consists of a growth chart printed on cloth 91 x 62 cm, with two sheets of symbols to cut out. Complete with a text describing learning exercises.

* National Association for Maternal and Child Welfare (NAMCW), UK (1980) Excellent leaflet series. How babies learn to talk; Helping hands (hands for fun games as well as developmental skills); Behaviour in early childhood; Care of child 1-2; Care of 3-5 year old.

National Children's Bureau, UK (1977) Development guide 0-5 years, experimental version. A handbook and summary chart in five sections: physical development, communication, self help and behaviour. It is intended for child carers to help them monitor what stage etc. the child is at and to encourage the child along the next steps.

New Zealand, Ministry of Health (1980) Health and development record. An amusingly illustrated guide to, and record of, child development.

GOING TO THE TOILET

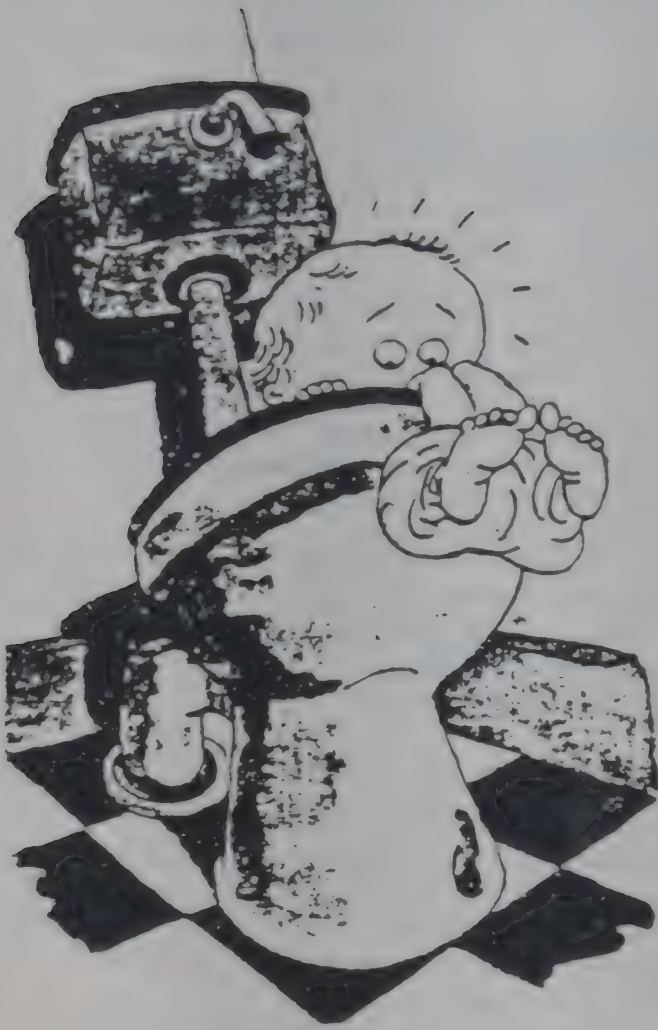


Fig. 3.5.

Until a child is at least 2 years old, his brain is still growing. His brain can't tell him when to go to the toilet.

So, wait till your baby is 2 years old. Then let him tell you, or show you, when he wants to go to the toilet.

Then:

show him how pleased you are,

seat him without delay on a pot,

or on a child-size lavatory seat.

* Odum, D. (? 1978) Understanding your child in the first five years. Booklet.

* Scottish Health Education Group (1980) The book of the child. (pregnancy to 4 years old).
An excellent book written for parents. See particularly the section on 'Your developing child' and the suggestions for developing movement skills in games (e.g. Fig. 3.6. below) There are many practical ideas for helping a baby to become mobile: pp.68-70.

DEVELOPING SKILLS USED IN GAMES	
The movement skills used in games can themselves each be turned into a solo or shared game. Here are some ideas to get you started.	
<i>Movement</i>	<i>What you need and what to do.</i>
BODY CONTROL—ALONE	
Running.	Room to run varying distances on different surfaces.
Turning.	Obstacles to run round and poles to turn or swing around on.
Jumping.	Obstacles to jump over, onto and off.
Balancing.	Lines or raised planks to walk along, wobbly things to try to balance on.
Body movement while stationary.	Touching body parts games like, 'do this, do that'. Bending, stretching and twisting the whole body. Getting through small spaces, filling large spaces.
BODY CONTROL—GROUPS	
Moving games.	Skiping and running, singing and clapping games such as 'ring o' roses' or 'the big ship' or 'oranges and lemons'. Stop-and-start games such as 'statues' or 'musical chairs'.
CONTROL OF OBJECTS, ALONE OR TOGETHER	
Carrying.	Boxes, blocks, balls. Places for carrying to and from. Holding and grasping, lifting and lowering, pushing and pulling games you invent.
Throwing (striking, kicking).	Beanbags, soft balls, large and small balls. Use large balls for kicking and small balls for throwing. Young children should not be expected to aim. Throwing for distance will cause them to improve by progressing to the next stage of throwing.
Catching (and stopping).	Beanbags, soft balls, large and small balls. Make this easier by rolling balls along the floor or on a raised surface. Large balls are 'caught' by trapping them against the body.

Fig. 3.6.

* Sheridan, D.M. (1973) From birth to five years, children's development progress, and Spontaneous play in early childhood (from birth to six years) (1977).

An important, unusual, well illustrated book and booklet. Explains that the provision of suitable playthings, playspace, playtime and playfellows for all children, and particularly for young handicapped children who cannot assert themselves, is of primary importance. The author distinguishes: (1) active play (crawling, running); (2) exploratory play (building blocks, sound

making); (3) imitative play (repetition); (4) constructive play (the combination of the former qualities with purpose e.g. building blocks); (5) make believe (pretend) play (expression of ideas in language-code); (6) games with rules (competition with peers at about age 4).

* Sheridan, M. Series of slides with scripts and tapes describing development of children.
Excellent material:

Definitions relating to developmental paediatrics.
(1968) 43 mins. 48 slides.

The needs which children have as they progress from infancy to maturity; the need for correct testing, so that the handicapped can have special care; the need to test for multiple handicaps.

Development of communication in young children.
(1974) 50 mins. 48 slides.

Milestones in the development of hearing and listening; how to observe departures from the normal.

Development of skill and ability in the normal baby.
(1966) 37 mins. 48 slides.

Describes in detail the stages in development from birth to one year of a normal baby, with some reference to abnormal development.

Development of vision in infants and young children.
(1968) 43 mins. 48 slides.

Milestones in the development of vision in babies, its relationship to hand-eye coordination.

Development of young children for nursery nurses.
(1977) 30 mins. 48 slides.

Spoken by Jane Chittenden. A simplified version of 'Development of skill and ability', above. Describes in simple terms the recognition of stages of development from birth to one year and beyond.

* Sheridan, M. (1971) Developmental examination. Series.
Step-by-step techniques of examination: motor, vision and hearing, social behaviour development at each of the following ages:

- (1) Six weeks and three months baby.
36 mins. 48 slides.
- (2) Six months old.
35 mins. 48 slides.
- (3) Nine months old.
28 mins. 48 slides.
- (4) Twelve months old.
37 mins. 48 slides.
- (5) Fifteen months old.
35 mins. 48 slides.
- (6) Eighteen months old.
35 mins. 48 slides.
- (7) Two years old.
35 mins. 48 slides.

- (8) Two and a half years old.
40 mins. 48 slides.
- (9) Three years old.
38 mins. 48 slides.
- (10) Four years old.
30 mins. 48 slides.
- (11) Five years old.
32 mins. 48 slides.
(This is not a school medical examination).

* **Sheridan, M.** (1974) The importance of play in children. A series of tape/slides.

- (1) Birth to three years of age. 46 mins. 48 slides.
For development, play is as important as protection, food, sunshine. Five main categories are described. Active, exploratory, imitation and make-believe games are needed for physical and emotional development.
- (2) Three to six years of age. 29 mins. 48 slides.
Early play merges into more sophisticated play with water, sand, floor, table, domestic, painting, blocks, educational toys, dolls house, books, stories, group pursuits.

* **Stallibrass, A.** (1974) The self respecting child. A study of children's play and development.
Includes the spontaneous play of healthy children, why and how babies learn, how adults can help children play.

* **Tanner, J.M.** (1961) Educational and physical growth. Written for teachers in schools. Presents salient facts and concepts of physical growth which have a direct bearing on educational practice. For example, the idea of developmental or physiological age derived from the greatly differing rates of physical maturation in children. Children of the same age in one class may be at very different physiological stages of development.

* **Tanner, J.M.** (1978) Foetus into man - physical growth from conception to maturity.
Describes the intra-uterine environment, the interaction of nutrition, stress and genetic factors in growth, and the commoner forms of growth disorders. Illustrated with a comprehensive collection of graphs, tables, diagrams and photographs. Written in a readable style.

* **Wyeth Nutrition** (no date) Leaflet series: How to make growing up child's play: 3-6 months; 7-12 months; 1-1¹/₂ years; 1¹/₂-2 years.

3.3.

Promoting emotional development

* **Bingham, J.** (no date) Do babies have worries?
This pamphlet is about the psychological and emotional development of infants. The authors think that "the feeling that we are loved, as adults, is wonderful; as infants, it is essential." Many forms of love are described: (1) affectionate love of parents accepting the limitations of the child; (2) dutiful love (because

of responsibility); (3) smothering love. Other aspects of child development - noisiness, possessiveness, fear, illness, fantasy, hostility - are each explained, with amusing diagrams showing the differences between parents who show affectionate, dutiful or smothering love.

* Illingworth, R.S. (1981) Your child's development in the first five years.

Three main questions are raised. How should he develop emotionally? (Chapter 2); How should he develop physically? (Chapter 3); How should he develop mentally? (Chapter 4). This is a parent's version of the book "The Normal Child". There are very useful sections on basic needs for emotional development: pp.13-21; and on helping him to be a nice person: pp.212-23.

* International Children's Centre (ICC) (1979) Infant stimulation pack. Eng. Fr. Sp.

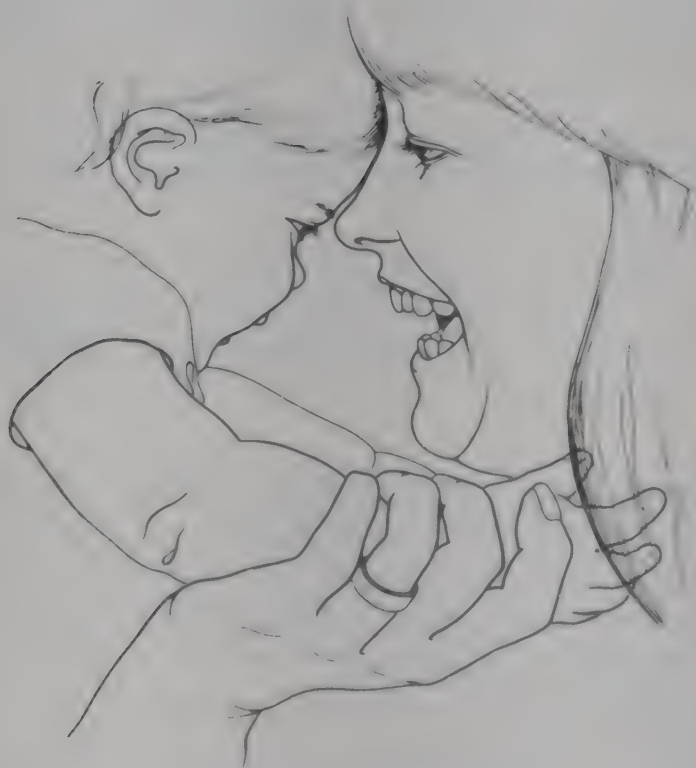
Written for parents/media/academics/professionals. Emphasises children's needs to be loved, talked to, wanted and played with.

* Leach, P. (1977) Baby and child from birth to 5 years.

Written for parents, covering all aspects of growth and development and their implications for play. There is a useful Appendix (pp.498-503) on playthings, explaining in three columns what he needs, why he needs it and suitable 'toys', many homemade.

* Morley, D.C. and Woodland, M. (1979) See how they grow.

Emotional growth is emphasised in Chapter 14: Play between mother and child is part of love and care: p.240. Physical growth is not enough; the child requires a stimulating and loving environment.



**Love
Growth
Confidence
Security**

Fig. 3.7: Play between mother and child is part of love and care.

* Newsom, J. and Newsom, E. (1979) Toys and playthings.

The starting point is the developing child, how a child changes

from one stage to another, and how certain toys can complement and expand this growth. Includes fun as part of personality growth.

Queensland Health Education Council (no date) Guide your child towards a healthy personality: questions for parents. Leaflet. Health Education Publication No.61. Includes 27 questions for parents, e.g. Do you keep your promises to the child?

Queensland Health Education Council (no date) Your children's happiness. Leaflet. Health Education Publication No.92. Includes sections on: children need discipline; children need play; children need love.

* Scottish Health Education Group (1980) The book of the child (pregnancy to 4 years old). The baby as a person - what he is interested in, can hear, can see: p.40. Suggests ways of: making a baby feel more secure: p.63; helping him talk: p.64; helping his development through four kinds of play (active play, play with the hands, pretend play, group play): p.68; teaching a child to be 'good': p.74.

* Swift, C.R. (1971) Mental health. Chapter 1: The life cycle and personality development; a review of personality formation during childhood, in the cultural context. Stresses the importance of maternal health during pregnancy and childbirth: infant care including feeding, particularly breastfeeding, and weaning practices has a bearing on emotional development. In traditional societies much education and child upbringing is based on the child-adult relationship. In 'modern' periods, the development of the child will be very much influenced by schooling. Urbanisation and rural-urban migration, and changes in the ways of lives of parents and families greatly affect emotional development.

UNESCO (1981) Cultural milieu, family environment and mental health of the child, by Holtzman, W. Division for the Study of Development Report. ChR 19.

UNESCO (1979) Trends in child development and mental health in Africa, by Durojaiye, M.O.A. Division for the Study of Development Report. ChR 1.

UNESCO, Regional Population Communication Unit, Kuala Lumpur (1977) Family welfare and family planning. Booklet 2. The emotional needs of the child (part of Module 1, Session 2):

- (1) A child needs to be loved and cuddled for him to develop a source of trust towards people.
- (2) The emotional stability of a child stems from the feelings of security provided in the home.
- (3) Parental support is needed for a teenager to develop his self-confidence and self control to cope with this changing period of his life.
- (4) Young adults need to be assured that the home is the place that they can always come back to for help.

Includes a table for discussion teaching: "What is responsible parenthood?"

Promoting language development and intelligence

Many of the books listed in Section 3.2. have some information on language development. 'Intelligence' development is often closely linked with physical milestones in the early years.

* CHILD-to-child programme (1979) Playing with younger children. Leaflet. Eng. Fr. Sp. Port. Arabic.
Riddles, songs and stories to give children confidence in using language. They also help the children understand their own culture and its values.

* CHILD-to-child programme (1979) Toys and games for young children. Leaflet. Eng. Fr. Sp. Port. Arabic.
Many ideas including a reading card game made at school by older children for younger children to use (see illustration).

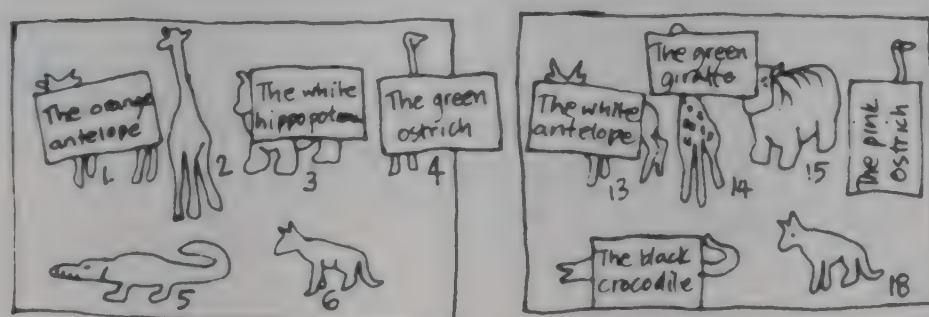


Fig. 3.8: A reading card game, made at school by older children for younger children to use.

* International Children's Centre (ICC) (1979) Infant stimulation pack. Eng. Fr. Sp.
See particularly the section on stimulation of language and intelligence in young children. This document is intended for health administrators and planners, and family organisations).

New Zealand, Ministry of Health (1980) Health and development record.

"Talk with your child": p.62.

TALK WITH YOUR CHILD

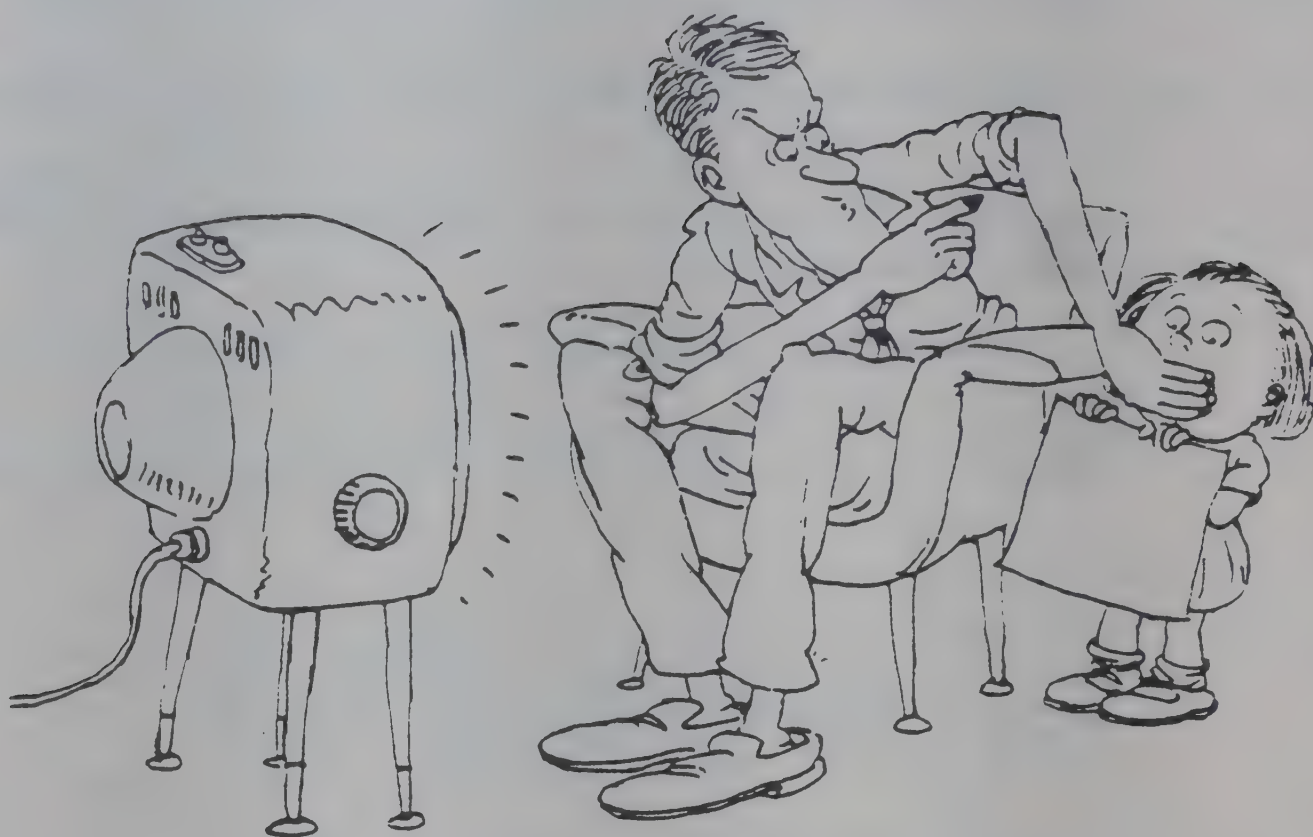


Fig. 3.9.

* **Scottish Health Education Group** (1980) *The book of the child* (pregnancy to 4 years old). Contains a very useful section on playing and learning: pp.68-77. Children need to experience as wide a variety of textures and materials as they can. They need to see how things fit or do not fit with each other (e.g. pebbles into a box, big boxes won't fit into smaller boxes).

3.5.

Promoting social and psychosexual development

See adolescent sex, details in Sections 4.3.2.13; 4.3.2.14. e.g. BBC (1976-1977) *Learning about life* (adolescence).

See Section 4.5.1. Teaching how babies come to be conceived and born.

Conger, J.J. (1977) *Adolescence and youth. Psychological development in a changing world.*

* **Ebrahim, G.J.** (1978) *Child care in the tropics.* Chapter 12: *The troubled teens.* Discusses the problems related to puberty, girls' reactions to menarche for instance. They learn from commercial advertisements rather than sex education in the 'permissive culture'. Psychological and social development is discussed.

Erikson, E.H. (1964) Childhood and society. Also (1968) Identity- youth and crisis.

Rayner, E. (1977) Human development and emotional growth. An introduction to the psychodynamics of growth, maturity and ageing. 2nd edition.

* Scottish Health Education Group (1980) The book of the child (pregnancy to 4 years old).
Section on Learning to play together: p.73. Describes the stages of learning to play with other children.

4. Promotion of mother and child health through birth spacing/ family planning.



4. Promotion of mother and child health through birth spacing/family planning.

4.1. Introduction: Training in birth spacing, family planning and help with sub-fertility

In contrast to child health training material, family planning training literature includes many short, well-produced documents, often in attractive booklet form. Much of this material is very cheap indeed. Not only is the material available at a level suitable for doctors, nurses and other professional health workers but it has also often been translated into a form which can be used with adults in the community, whether educated or not. Poverty and population are closely linked, as shown in the diagram below. Comprehensive care of children under 5 years old, and birth spacing may influence the poverty cycle at a number of points.

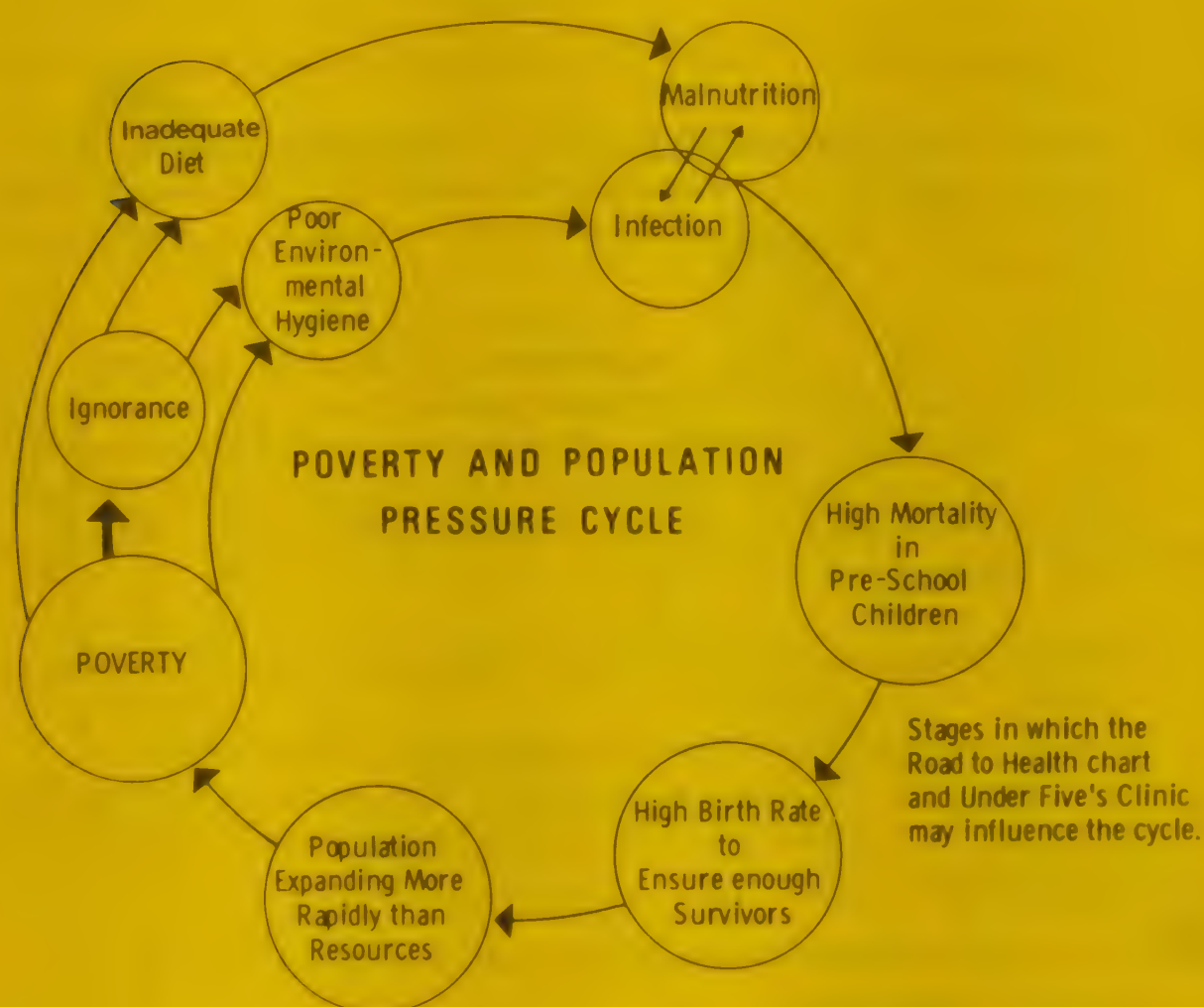


Fig. 4.1: Poverty and population cycle. Comprehensive care of children under the age of 5 years and birth spacing may influence this cycle at a number of points.

Morley, D.C. (1973) Paediatric priorities in the developing world.

4.2. The health benefits of birth spacing

4.2.1. Healthy mothers

- * **Columbia University, Centre for Population and Family Health** (1981) Family planning: its impact on the health of women and children.

A booklet explaining simply the links between birth spacing, family size, maternal deaths, infant deaths, birth order, induced abortion, contraception and family planning. Examples are taken from Chile, India, Turkey, Lebanon, El Salvador. Includes colour graphs showing trends in family health. The pictures may be reproduced.

- * **IPPF** (1976) Spaced births mean healthier mothers and children. People 3: pp.7-9. Eng. Fr. Sp.

- * **IPPF** (?1976) Strong and healthy mothers and children; notes on child spacing for health, social and welfare workers. A useful film and/or tape-slide set.

- * **Morley, D.C.** (1973) Paediatric priorities in the developing world.

Chapter 18: Birth interval and family planning. Includes an examination of the reduced "mothering time" when there are more than two or three children under 5 years of age being looked after together.

- * **Papua New Guinea, Department of Public Health** (1975) (1) Family planning for aid-post orderlies and nurse aides. 35pp. (2) Guide for teachers of aid-post orderlies and nurse aides. The need for family planning for the mother's health: p.3. Four reasons for family planning are explained in simple language. Very useful.

UNESCO, Regional Population Communication Unit, Kuala Lumpur (1977)

Family welfare and family planning. Booklet 2. The benefits of family planning for mother and child: Module 1, Session 1. Presented as teaching material ready for use in discussion.

4.2.2. Healthy children

- * **Ecuador** (1976) Birth spacing reduces infant deaths, optimum spacing between births is 27-38 months. International Population Digest 2 (3): p.11.

- * **Fedrick, J. and Adelstein, P.** (1973) Influence of pregnancy spacing on outcome of pregnancy. British Medical Journal 4: pp.753-756.

- * **Fuglesang, A.** (1982) About understanding - ideas and observations on cross-cultured communication. 231pp. The concept of birth spacing; the necessity for spacing eucalyptus trees is related to the necessity for spacing births: p.208.

* Jordon, Family Plannning and Protection Association (no date) Strong and healthy mothers and children. Eng. Arabic. The reasons for and the advantages of maternal and child health services are clearly explained.

Lancet (editorial) (1978) Interval between pregnancies. Lancet 2 (8095): pp.879-880.

* Martin, E.C. (1978) The effect of birth interval on the development of nine year old school children in Singapore. IPPF Medical Bulletin 12 (3): p.1. Eng. Fr. Sp.

Martin, E.C. (1979) A study of the effect of birth interval on the development of 9 year old children in Singapore. J. Trop. Paediatr. 25: pp.46-76.

BIRTH INTERVAL, MEASURES OF INTELLIGENCE AND GROWTH
560 SINGAPORE CHILDREN, AGE 9 (Martin E.C.)

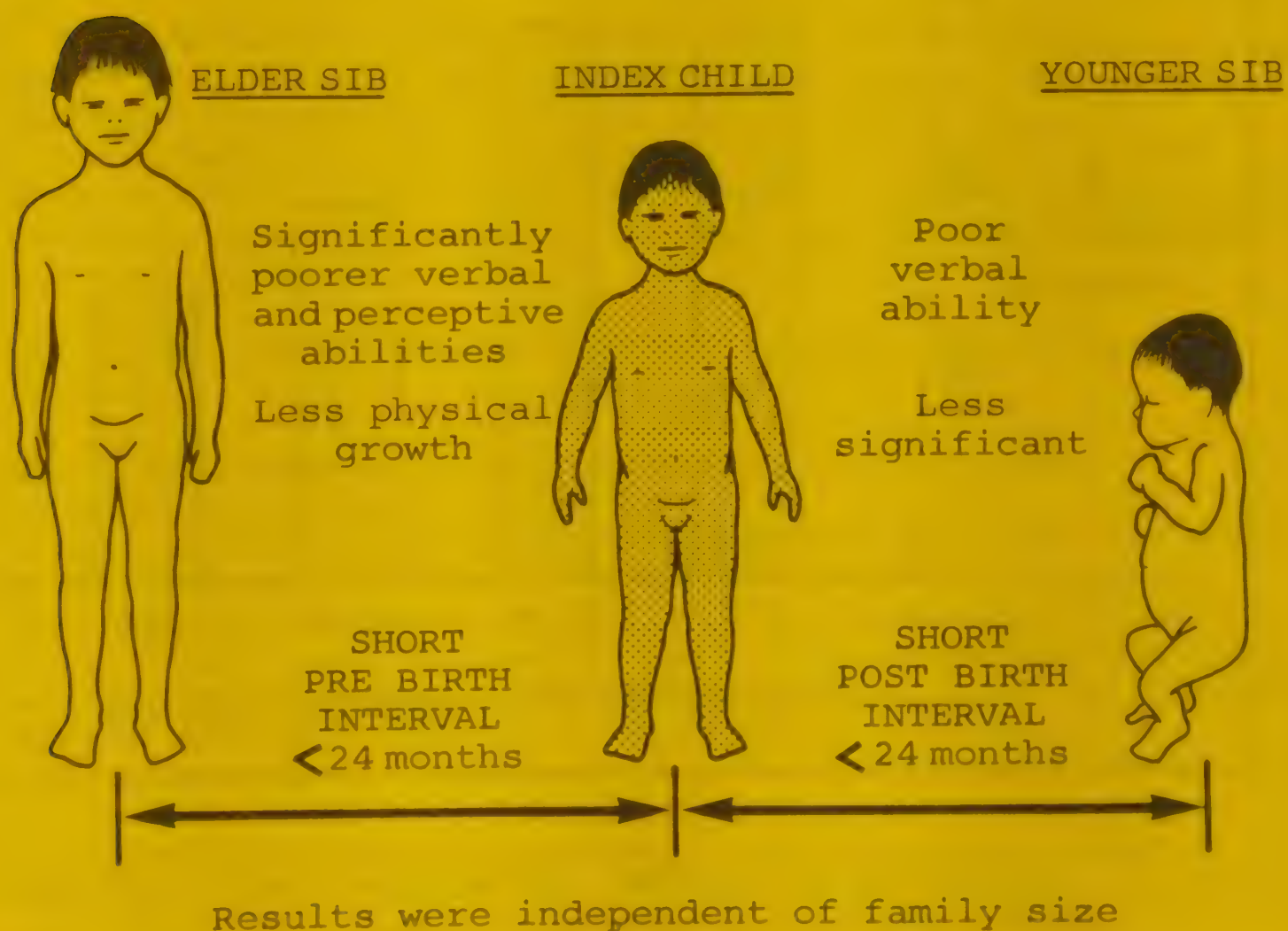


Fig. 4.2: Source TCHU. This picture may be reproduced.

* Morley, D.C. (1977) Biosocial advantages of an adequate birth interval. J. Biosoc. Sci. Suppl. 4: pp.69-81.

* Morley, D.C. (1973) Paediatric priorities in the developing world.

Chapter 18: Birth interval and family planning. Contains a

useful section on the effects of a short birth interval on child death and sickness.

Mudkedkar, S.N. and Shah, P.M. (1976) The effect of spacing of children on the nutrition and mortality of under-fives. Indian Journal of Medical Research 64: pp.953-958.

Papua New Guinea, Dept. of Public Health (1975) Family planning for aid-post orderlies and nurse aides. 35pp.
The need for family planning for the baby's health: p.4. Three reasons are clearly explained within this excellent manual.
Proportion of children malnourished according to birth interval (Indian study).

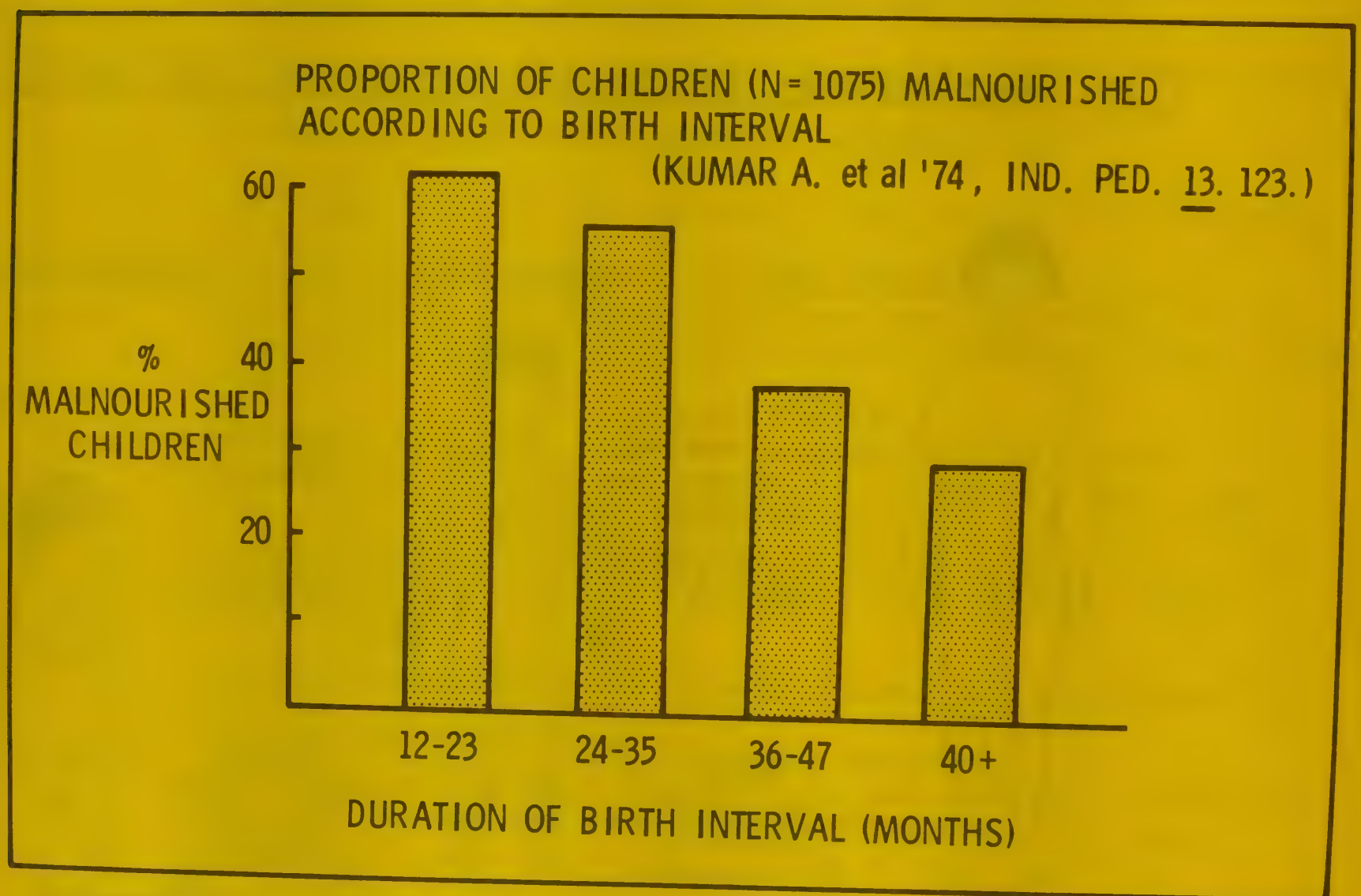


Fig. 4.3: Source TCHU: This picture may be reproduced.

* Spacing births reduces deaths: illustration.

SPACING BIRTHS REDUCES DEATHS

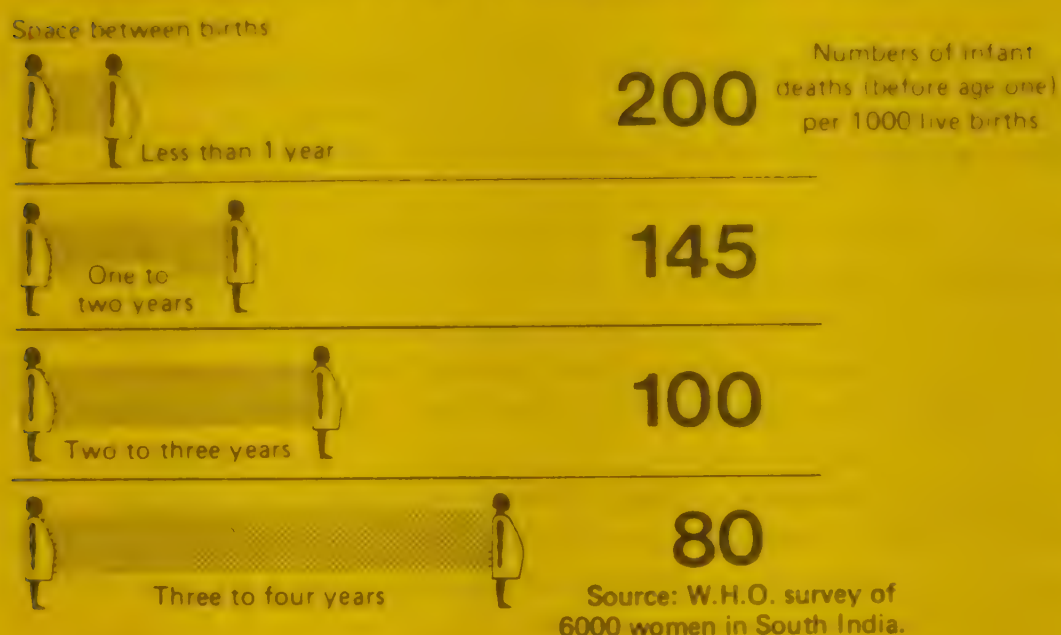


Fig. 4.4: Source TCHU: This picture may be reproduced.

* Togo, Ministry of Public Health (1976) *Le bien-etre familial par l'image*. 28pp. Republique Togolaise projet TOG/76/PO3. Programme national de bien-etre familial.

A booklet with good line drawings that would be useful for many parts of Africa. It tells the story of how a family is like a field and needs cultivating in the same way. Plants need spacing and so do children: p.9.

WHO (1970) *Health aspects of family planning*. Tech. Rep. Ser. No. 442.

WHO (1971) *Health education in health aspects of family planning*. Tech. Rep. Ser. No. 483.

Maternal mortality risk is slightly less with the second and third pregnancies than with the first, but rises with each pregnancy beyond the fifth. Infant mortality rises rapidly from the fifth birth onwards. Low birth weight and preterm babies increase with parity. The book makes six recommendations to reduce the risks of maternal and infant mortality: (1) The first pregnancy should occur at between 20-24 years of age; (2) Children should be spaced at intervals of 3 years (1-2 years should elapse between the end of lactation and the next pregnancy); (3) Pregnancies should be avoided after 35 years of age; (4) Unwanted pregnancies should be avoided; (5) The number of pregnancies should be reduced to prevent maternal exhaustion; (6) Infertility should be treated.

4.2.3.

Happy families

ILO (1973) *Hard up Joe*.

A comic book telling the story of how things become difficult for Joe as his family grows larger and larger.

Macagba, R.L. (1978) *How to have a healthy family*.

A pictorial booklet in four sections, including one on the

importance of family planning. There is little text but many drawings are included.

Mexico, Fundacion para Estudios de la Poblacion (1976)

Alimentacion y paternidad responsable.

A comic pamphlet showing population problems.

Morocco, Family Planning Association (1967) La planification familiale. Fr. Arabic.

A picture book telling the story of why Ahmed chose to practise family planning so that the family would benefit. The family learns about the pill, the condom, and the Lippes loop.

* **Papua New Guinea, Department of Public Health** (1975) Family planning for aid-post orderlies and nurse-aids. 35pp.

See pp.4, 5 for straightforward explanation of the need for family planning for the happiness of the family. Line drawings accompany the text.

Rank Organisation (1974) Family planning animated cartoon film. 10 mins, colour.

"Family Plan" is a WHO film which stresses the health benefits of family planning - not as an end in itself, but as a powerful means to achieve better health for the family in general and for mothers and children in particular. The film combines the traditional humorous elements of the cartoon with serious themes emphasising the responsibility of procreation, the role of the individual, and the importance of harmony within the family.

UNESCO (1979) Development foundation booklet 5: Stories in search of writers.

"During one year, how many babies are born in your country?
How many people die?

What is the increase in your country's population?

Reduce this value to the number per month (divide by 12);

then to the number per day (divide by 30);

then to the number per hour (divide by 24); and

then to the number per minute (divide by 60).

How many people are added to your country's population every minute?

Is that worth a story?

1. Monitoring your national family planning programme.
 - a. What are the major activities?
 - b. With what results?
2. Is there any research on new methods of family planning in any of your national institutions?

What are they trying to do?

 - b. How far have they gone?
3. What are the local prejudices against birth control programmes in your country?
4. Are there incentives offered for family planning in your country?
 - a. What are they?
 - b. What is the extent of the response?
5. The following questions may be added to each of the above if appropriate:

- a. How was it in the past?
- b. Was there progress? Failure? Why?"

* UNESCO, Regional Population Communication Unit, Kuala Lumpur (1977) Family welfare and family planning. Booklet 2. Includes true/false statements for discussion and instructions on how to prepare 4" x 4" fact cards.

"Spacing births

- 1) It usually takes 2-4 years for a woman to recover her normal health after having a baby. TRUE
Discussion: A woman needs at least two to three years to recover fully from one pregnancy and prepare for another. If a woman gets pregnant too soon it will lead to premature ageing and possibly to early maternal death. After delivery the mother's body needs to replenish its nutrients. The more poorly nourished a woman is, the longer the period of time she should wait before having another baby. (Source: May, Manisoff)
- 2) Children that are born close together, less than 1 year apart, tend to be more sickly on the average than children born 2-4 years apart. TRUE
Discussion: A study conducted in India concluded that children who are born closely together run a higher risk of dying during the first two years of life than those children who are spaced. The study said that the optimum spacing period between births was about 3 years. (Source: Wyon and Gordon, Knodel)
- 3) There is no difference between the mental development of children who are born less than one year apart and children who are spaced. FALSE
Discussion: A study has shown that infants who are born closely together have a lower birth weight, lower rate of development at 8 months and lower IQ scores at 4 years than children who are spaced.

(Source: Holley et al)...."

"Should they have a child or should they wait?: Case Study A:

Ali earns \$180 per month as a driver. Sometimes he makes a little extra by driving his boss in the evenings or when he goes outstation. When he first arrived in Kuala Lumpur he had difficulty finding a job or accommodation, but he managed to get a job and after a few months he found a space in an outlying area of Kuala Lumpur to put up a 2 room wooden house. He feels lucky that he does not have to pay rent, but the house does get flooded when it rains heavily. The house has no electricity and he has to get his water from a public tap 20 yards away. In the morning he fills 3 containers of water so that his wife need not carry the water during the day.

He married Aminab when he was 21 years old and now, 4 years later, he has 2 children aged 2¹/₂ years and 6 months. Aminab had a difficult time during her second delivery as the baby was premature because she was suffering from anaemia.

However she has been able to breast-feed the baby and it seems to be healthy. She now gives it a little powdered milk.

Aminab has thought of going to the family planning clinic but Ali

is not sure of the safety of the methods. He has heard of some of the dangers of using these methods. Furthermore he would like to have another child right away.

Some of the reasons why Ali and Aminab should not have another child right away:

- a. Ali's income is low. Can he really afford to provide for all the needs of another child? Food? Education? etc?
- b. Aminab's health was not good during her last pregnancy. She should wait at least until her youngest child is 2-3 years old before she has another child. It will take this long for her to get her full strength back.
- c. There is a greater chance that the health of their baby will be better if they wait $1\frac{1}{2}$ more years before Aminab gets pregnant again. It has been shown that babies that come too closely together are not as healthy as babies spaced 2-3 years apart.
- d. Ali's present house has neither electricity nor water supply. This lack of facilities places a burden on Aminab. Another child would be likely to add to this burden.
- e. Because Ali's house has only two rooms, it is likely to be cramped when his two children grow up. A third child will add to the feeling of congestion.
- f. A third child at this time would require a lot of Aminab's time and attention. Could she look after her other children as well? Could she pay sufficient attention to her 6 month old baby?

* Werner, D. (1977) Where there is no doctor.
Family planning: pp.282-294.

Werner, D. and Bower, B. (1982) Helping health workers learn.
Chapter 23: Family planning. Why do poor people need many children? They are an economic necessity. By the time a child is 12 he/she produces more than he/she costs. By 15 years of age, a child has produced as much as he/she has cost the family since birth.

Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (no date) La jeunesse et le probleme des naissances desirables. Booklet No.11. Fr.

4.3.

Introducing birth spacing/family planning to the community

4.3.1.

Finding out about the community's needs for birth spacing/family planning

4.3.1.1.

Finding out about the local community

* Huston, P. (1977) Power and pregnancy. In: New Internationalist, Population Special, Number 52: pp.10-12. Report on a special survey in six countries, for the United Nations Fund for Population Activities, finding out rural women's attitudes to family size. Concludes that women now want smaller families. If family planning programmes are to succeed, they need to direct the message at men. Case studies prove the point in Mexico, Sri Lanka, Egypt, Kenya and Tunisia. Useful material for teaching.

IPPF (1971) Communicating family planning. Eng. only. Starts by suggesting ways of finding out about the community, i.e. numbers of people, attitudes, community structures, traditional and modern communication methods available.

* IPPF and American Universities Field Staff (1975) Women in a changing world. 50 min. film. Report In People 2 (2).

Eng. Sp.

Ordinary women from four countries (Afghanistan, China Coast, Kenya, Bolivia) talking about their everyday lives, their feelings about being pregnant, etc.

Leidenstein, S. (1979) Learning about rural women. Studies in Family Planning 10 (11/12). Special Issue.

A variety of methods of understanding rural women from various areas of the world (India, Java, Mexico, Africa) are described. Including anthropological, sociological and demographic techniques. Also includes important studies on how rural women perceive themselves.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

KEY QUESTIONS FOR DISCUSSION ABOUT FAMILY PLANNING



- How many children does the average couple have in our community?
- Who usually have more children—rich families or poor ones? Why?
- What are the advantages of having many children? Of having few children? If you are rich? If you are poor?
- What are the attitudes of most of the people in our community toward family planning? Why?
- Do the men often have different attitudes than the women? Why?
- How do large families affect the population (number of people)?
- Is the number of people in our village or community growing? Is there enough land (or work or food) for everybody? Are things getting better or worse? Why?
- Do some persons or families leave the village to move to the city or another country? Why? What sort of life do they lead there?
- Do you think that the growing number of people is partly responsible for the hunger or hardship of the poor? What else do you think is responsible?
- What does the government do about these other causes? About family planning? Why? Where does the money for this come from?
- Official announcements tell people they should plan their families in order to protect the health of mothers and children. What other reasons do you think the officials might have?
- What doubts or fears do you (or mothers, or people in general) have about different family planning methods? Why? Where can you get truthful information?
- In what ways do family planning programs meet people's needs? In what ways do they abuse people? What have you yourself experienced?
- Do you think family planning workers should be required to sign up a certain number of new users each month? Why? How would this requirement affect the way health workers relate to people?



- Should parents be rewarded (given 'incentives') for planning their families? Why or why not? How does the incentive system affect people's attitudes about family planning? About the government? About themselves?



- In many countries, illegal abortion is the most common form of 'family planning'. Why? What are the results?
- Is it better to abort or to bring an unwanted child into the world?
- Is it just and fair for men to make the laws about abortion and other issues concerning women's health and lives?
- Is family planning important? For whom and in what way?



- Should a health worker encourage parents to plan their families? All parents? Only some parents? Which? Should a health worker bring up the subject of family planning when mothers come for medical care or bring their children? Should she discuss it with them only when they express interest? Or should this depend on the problems and needs of the individual family?



- Whose needs does family planning presently meet in your area?
- How could it better meet the needs of the poor?
- What can we do about it? What will happen to us if we speak out or take action? Is it worth it?

Fig. 4.5: 23 key questions for discussion about family planning.

4.3.1.2.

Finding out the pattern of birth interval in the community

* TCHU (1982) A simple method of calculating the months between births. Free.

Leaflet with instructions for health workers to calculate birth interval. The method of calculating is explained with the help of a diagram. The back page explains the advantages of birth spacing to the child and the mother and what risks are inherent in too short an interval between births. A concise summary of important birth interval topics:

- 1) Calculating the vulnerable group for a short birth interval in your community.

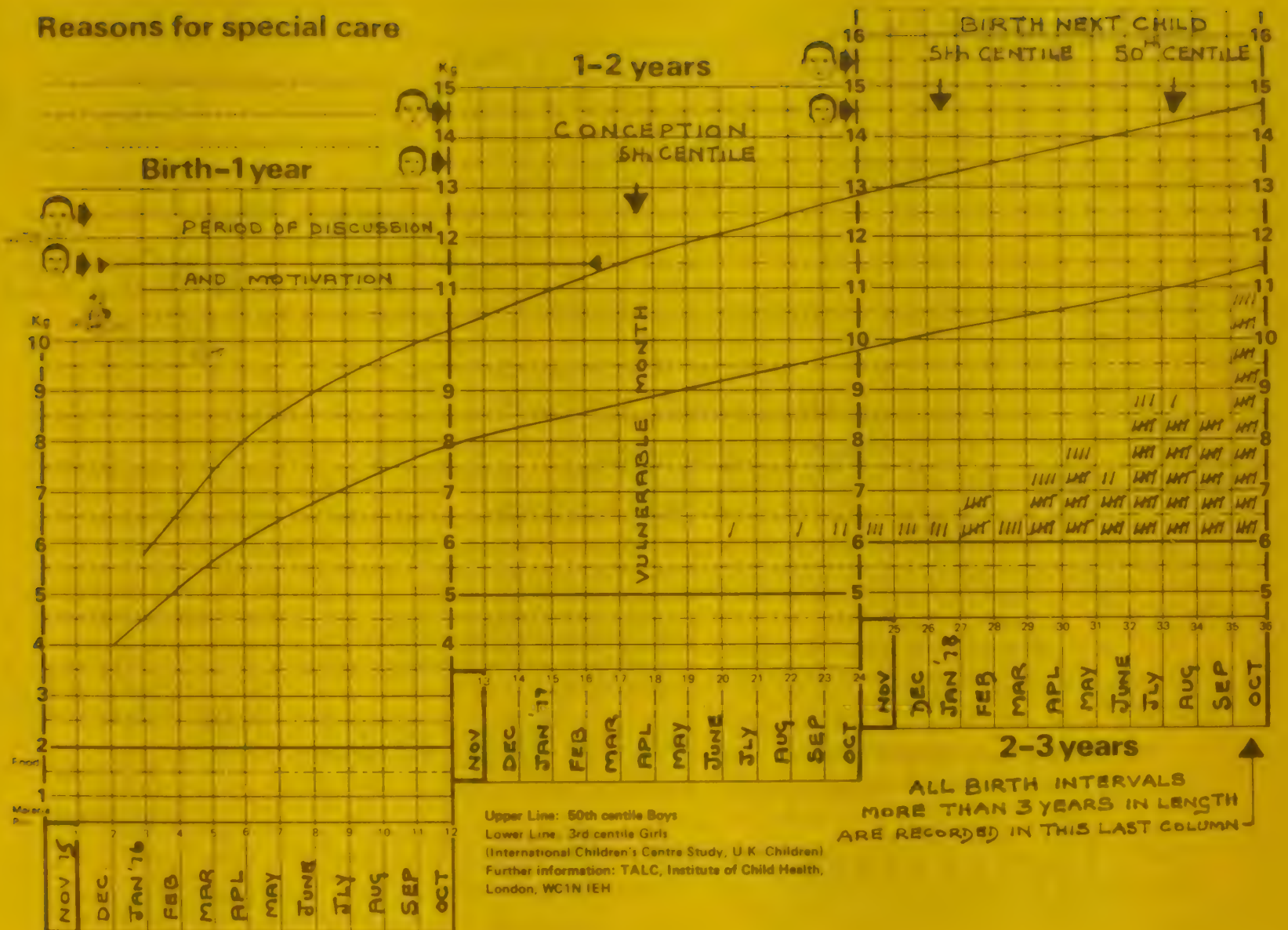


Fig. 4.6: Diagram A: Source TCHU.

The number of months between the last two deliveries (the birth interval) of 200 women has been marked on this chart. August 1978, the month after which the 100th birth interval (the middle of the sample of 200) occurred has been labelled the 50th centile. This is the middle birth interval, of 34 months, i.e. half the sample had this length of birth interval or longer and the other half of the sample had this interval or shorter. In this sample the chart shows that many women do have a reasonable interval, of 34 months, between births.

However, when the month after which the 10th shortest birth interval occurred is labelled the 5th centile, (in this case the 27th month) it is apparent that a proportion of the women in the sample, (and probably the whole population) are at high risk of having children born too close together. 9 months before the 5th centile month is thus identified as the vulnerable month by which time birth spacing/family planning advice needs to have been taken.

2) Planning services for the vulnerable group at risk of a short birth interval in your community.

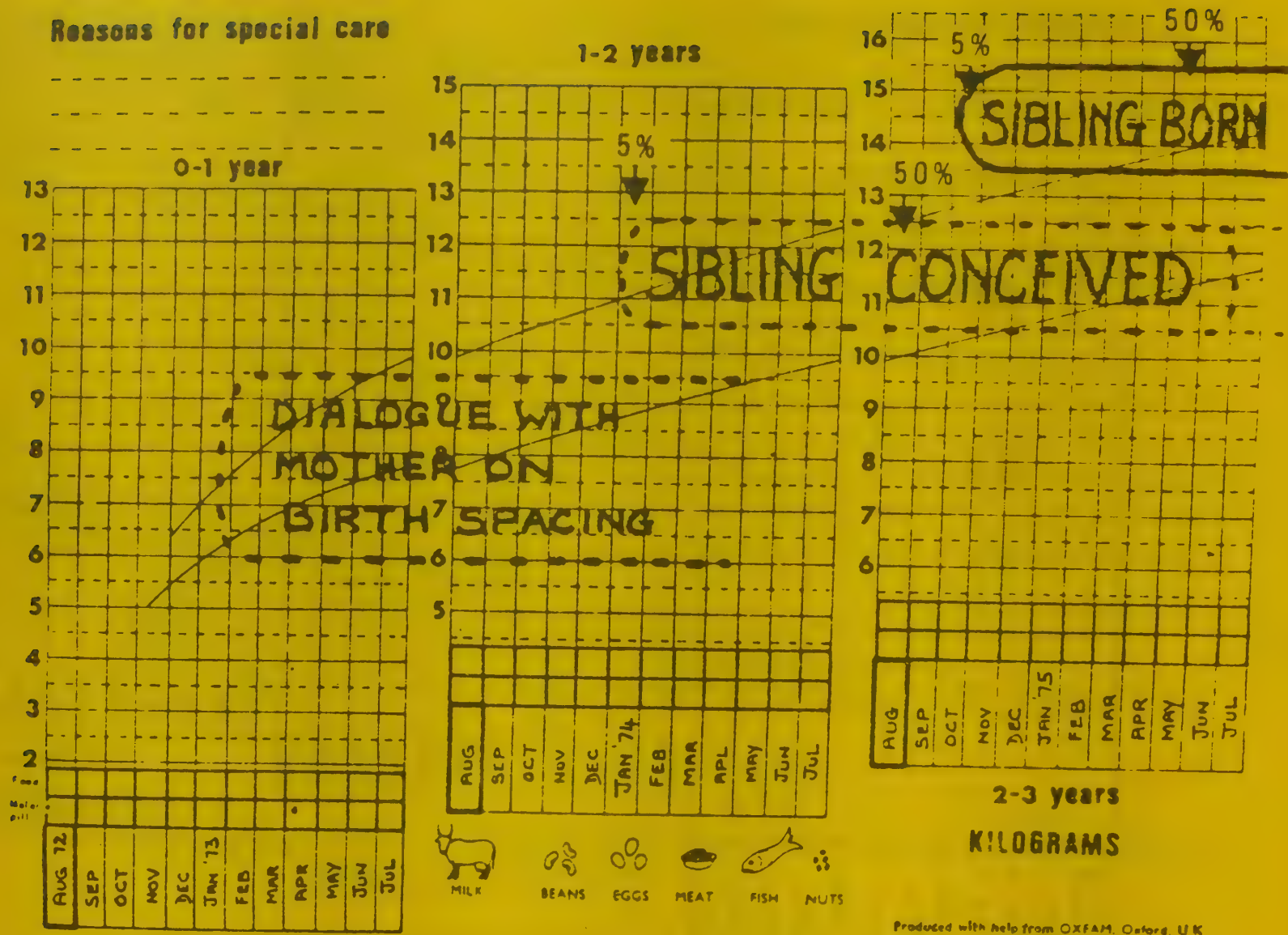


Fig. 4.7: Diagram B: Source TCHU.

This diagram shows the implications for birth spacing services drawn from the calculation shown in diagram A. 5% of siblings are likely to be born by the 27th month postpartum and 50% by the 34th month onwards.

Conception will occur in 5% of mothers by the 18th month and in 50% by the 25th month. Thus, advising the parents about birth spacing needs to take place in the 6th month onwards postpartum, and needs to be aimed at the very vulnerable 5% of the population most at risk of a short birth interval (less than 27 months) which is likely to result in injurious effects on the mother and her children.

4.2.1.3.

The demand for family planning services shown by induced abortion

* Potts, M. (1981) More marketing than medicine. People 8 (2): pp.6-7. Eng. Fr. Sp.

Many maternal deaths each year are associated with illegal abortion (e.g. 24% of deaths in a maternity hospital in El Salvador, 50% of maternity related deaths in Santiago, Chile). The data is taken from: Eckholm, E. and Newland, K. (1977) Health, the family planning factor. Worldwatch Paper No.10. Potts points out the huge numbers of induced abortions (anually 35-55 million): each indicates an unwanted pregnancy. Women are prepared to go to extensive lengths, risking their own lives, to

avoid taking such unwanted pregnancies to term. He argues that such women are deeply committed to planning their families. They are highly motivated to use a modern technique to avoid becoming pregnant. Yet so much of family planning work is restricted to "motivating" people. They do not need "persuading". What is needed is provision of the services and technology so people can take action themselves.

4.3.1.4.

Recognising people need healthy children to supplement the family income

* **New Internationalist** (1978) People who need people. No.68. pp.10-11: Verbatim conversation with some young Indians:
"If I don't have children, who will look after me when I am old or ill-nobody else will help me..."
"Nearly half the children around here die before they are grown up; I am going to have several children so that even if some die, I will still be left with some...."
"What else can a woman be in life except a mother and a home-worker. I never had an education and a job or a career..."
"If I have children, one or two of them might go to school and a get a good education or go off to the town and get a good job. Then they will be able to send money back like Mr. Rashid's children do...."
"They say it makes you old and ill very quickly if you have too many children too close together. And anyway perhaps I would be able to look after my children better if I only have two or three. But it is not really my choice. My husband will decide...."

* **New Internationalist** (1977) Population Special Issue. No.52.
See illustration "Children, the benefit to the poor; the cost to the rich": pp.16-17. Contrasts the need for children to help with planting and harvesting, to hoe, to weed, to grow vegetables, to cook, to clean, to look after younger brothers and sisters, to collect wood and water and look after animals, with, on the other hand, the cost of toys, books, games, bicycles, wristwatches, record players, fashion clothes, telephone bills and holidays, school uniforms, educational "trips", music lessons and games kits. In the first situation children are contributors to the family food and income from an early age. In the second situation this may not happen till children are in their mid-twenties, or not at all.

4.3.1.5.

Evidence of unmet needs for contraception and of population and economic pressures nationally and locally.

Chinese Centre for International Training in Family Planning, Taiwan (1973) Paste your umbrella before the rain; planning today for tomorrow.

A local saying used as a basis for family planning teaching. This is a good example for other countries to take their local proverbs as a basis for health teaching.

Cyrus, A. (1976) The story of Stumpy, Jean and Lena.

Egypt, Family Planning Association (no date) Posters in Arabic for general motivation.

Egypt, United Nations Development Programme (UNDP) (no date) Posters in Arabic: Happy life and the small family.

"It is enough to have Randa and Alanda and you will live in happiness. It is not a matter of numbers, it is a proper child education that counts. A small family is a happy family. The smaller, the greater the happiness".

* Hurd, E.T. and Hurd, C. (1973) Wilkie's world.

India, National Institute of Family Planning (1964) The family planning problem.

A flipbook of seven Indian statistical charts showing population growth in relation to food grain production. A good example of the sort of material that could be produced locally in other countries.

* International Family Planning Perspectives (1982) The unmet need for contraception 8 (4). Special Issue.

IPPF (quarterly) Family planning in five continents. Available on subscription. Eng.

* King, M. (ed.) (1966) Medical care in developing countries. A graph of the population explosion and the number of productive acres per head: Section 18:3.

The number of potentially productive acres per head forecast until the end of the century for several developing countries.

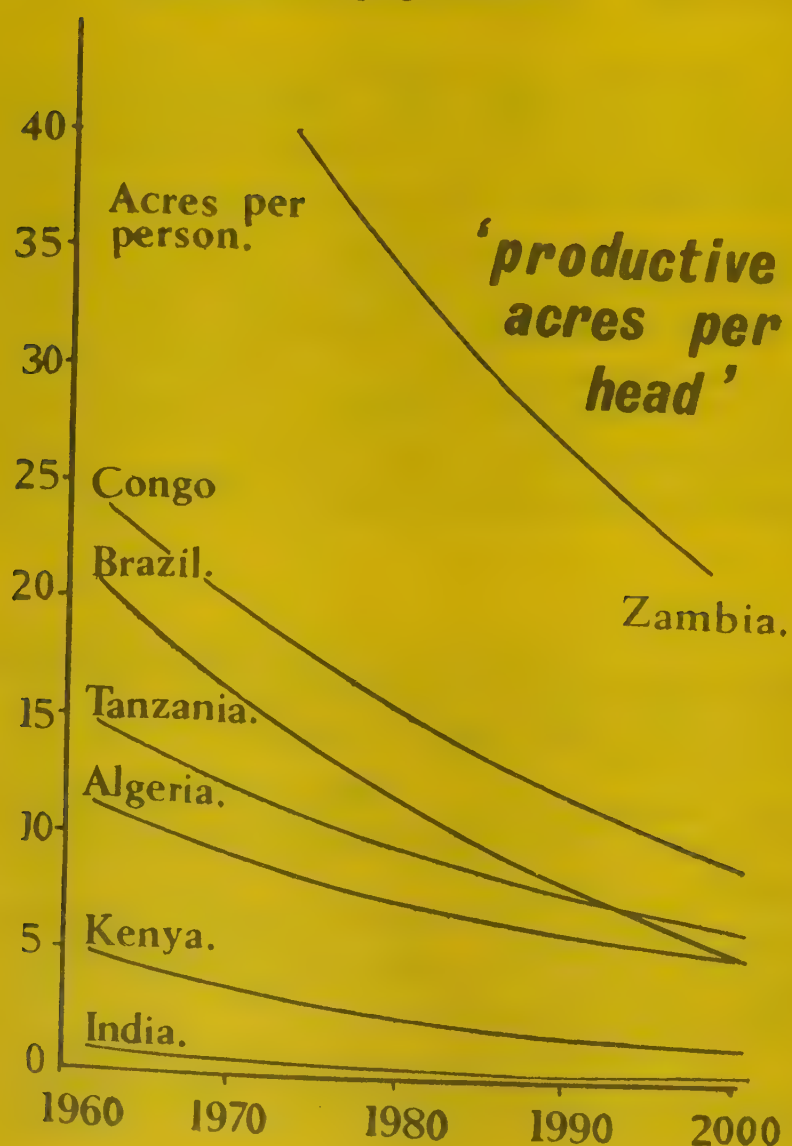


Fig. 4.8.

Mexico, Consejo Nacional de Poblacion (1974) Mejor vida para le poblacion de Mexico. 34pp.

Morocco, Ministry of Health (no date) Planification familiale et population au Maroc. Arabic, Fr.

Well illustrated; covers the population between 1970 and 2000 in the world and in Morocco. One infant is born each 43 seconds, i.e. 750,000 per year. Declining mortality from 1920-1970 is causing an increased population which leads to problems of: lack of food (agricultural production); lack of schools; lack of houses; lack of employment; informing two million couples that planned families improve the health of the mother, and about the methods available (the pill, IUD, and condom are photographed). Gives population projections for Morocco with and without family planning. It is useful source material as an example of what could be produced for other countries.

Sai, T.F. (1977) Population and national development - The dilemma of developing countries. IPPF Occasional Essay Number 2. Eng.

Analyses some reasons for the population explosion in the world (fall of death rates, fewer wars in some areas, better health care than before in some places, etc.). Identifies the problem of rapid urbanisation, also the rising demand for education, employment. Has many diagrams.

Tunisia, Association Tunisienne du Planning Familial (no date) Poster in Arabic and French; Pensez a mon avenir; limitez le nombre d'enfants.

UNESCO, Population Education Section (1982)

Titles available include:

- (1) Study of the contribution of population education to educational renewal and renovation in El Salvador, The Republic of Korea, Philippines and Tunisia.
- (2) Socio-cultural case studies for population education in Morocco, Peru, Wanda, and the United Republic of Tanzania.
- (3) Education Studies Document No.28. Population education: a contemporary concern.
- (4) Education en matiere en Haute Volta.
- (5) African social studies programme; population education source book for sub Saharan Africa.
- (6) UNESCO, Regional Office for Education, Asia and Oceania (1980) Syllabi and course content outlines integrating population education in non-formal development programmes (1-3).
- (7) UNESCO, Regional Office for Education in Asia and Oceania (1980) (i) literacy, (ii) agriculture (iii) labour, (iv) health, (v) rural development, (vi) out of school.
- (8) UNESCO (no date) Estudio de referencia sobre education en poblacion para America Latina - programa regional de education en poblacion OREALC - UNESCO. Sp.
- (9) UNESCO, Regional office for Education in Asia and Oceania (no date) Building your population education collection. Six booklets: (1) Building your population education collection, (ii) Recommended titles, (iii) Directories, (iv) Population education programme inventory, (v) List of sources and resources for in-school population education (parts I and II), periodicals

and audio-visual materials on population education (Part III),
(vi) Making lists and dissemination of documents.
(10) UNESCO, Regional Office for Education in Asia (1975)
Population education: a source book.

* UNESCO, Regional Population Communication Unit, Kuala Lumpur
(1977) Facts about population. Booklet 5.

Part 6 compares community needs in the year 2050 in a three child
and in a five child family. Gives a useful table to be used as a
worksheet, comparing the number of primary schools, community
clinics, houses, water treatment plants, electric generating
plants, jobs, and miles of roads that would be needed.

* UNICEF/Population Reference Bureau (no date) Data sheets.
Country data on: 1) Population; 2) children; 3) women. Useful
because they show the national average, although they may hide
large variations within a country.

* World Bank (1973) World Bank atlas.
Includes per capita increase, population and growth rates.

* World Conference on the UN decade for women, Copenhagen
(1980) Women work twice as hard as men.
A card folder with photographs, graphics and cartoons dealing with
women's labour in many rural areas of the world. Articles on:
The future of women, The cheap labour of women, Women work twice
as hard as men. A report from Botswana - Life without men - on
the situation experienced in many countries when half of the male
population have left for other countries to find employment.

4.3.2. Providing and evaluating birth spacing/family planning services

4.3.2.1. Birth spacing by child weight not age

* Rohde, J.E. (1975) Pregnancy spacing by child weight. Lancet
2: p.853.

Suggests that where the village commerce is run by women and they
are thus familiar with weighing and weight, they should be advised
to postpone pregnancy until a child weighs at least 13 kg. (28.7
lb) when susceptibility to infection is reduced.

4.3.2.2. District planning, organisation and evaluation of birth spacing services

* El-Bushra, J. and Perl, S. (1976) Family planning education
in action; some community centred approaches. Eng. Sp.

Gray-Lucas, B.C. and Gray-Lucas, P. (1978) The functions of a
family planning association; a management handbook. 2nd edition.
Eng. Fr.

Includes a handy checklist stating: what needs to be done; the
criteria for a good organisation: p.25; what staff need from an
organisation: p.30.

* IPPF (1976) Training and development omnibook.
Aims to bring together in one composite volume a collection of

useful materials for training and development.

Reynolds, J. (1973) A checklist for evaluation of family planning program activities.
Manuals for the evaluation of family planning and population programmes.

Sai, T.F. Defining family health needs, standards of care and priorities, with particular reference to family planning. IPPF occasional paper Number 4. 29pp. Eng.
Shows how family health needs can be determined (through demography, mortality, morbidity, nutrition status, community concern) in a community, and the setting up of priorities based on these needs. The section on family planning deals with the advantages of birth spacing to both mother and child health and the community.

* UNESCO (1976) Evaluation research on family planning communication. Population communication technical documentation No.4. Eds. E.M. Rogers et al.
Reference material.

* UNESCO (1981) A manual on evaluation of population communication programmes by Robert Gillespie. UNESCO Manuals on Population Communication No.2.

World Bank (1979) Family planning programs, an evaluation of experience.
World Bank Staff Working Paper No.345.

WHO (1973) Family planning in the education of nurses and midwives. Public Health Paper No.53. Eng. Fr. Sp. Russian.

WHO (1971) Health education in health aspects of family planning. Tech. Rep. Ser. No.483.

4.3.2.3.

Health centre planning, organisation and evaluation of birth spacing services

* IPPF (1978) Family planning programme management. IPPF bibliography series.

A useful annotated bibliography. Topics include planning, decision making, personnel management, financial management, clinic management, workshops and meetings, training.

4.3.2.3.1.

Task analysis and goal setting for health centre birth spacing services

* Afghanistan, Ministry of Public Health (1977) Basic health centre manual. Task analysis of what needs to be done at health centre level. Many topics are covered very well. e.g. infertility: p.245.

* Ghana, Ministry of Health and Department of Community Health, University of Ghana Medical School (1977) Manual for family planning training course for serving personnel and nursing

training schools.

Lists the objectives of a family planning training course, with outline lessons and practical exercises for a course. A useful low-cost document, it could be adapted for other countries and used as a basis for designing an illustrated rather than written document for village workers.

Ghana, Ministry of Health and Department of Community Health, University of Ghana Medical School (1977) Instructor's guide for: manual for family planning training course for serving personnel and nursing training schools.

Brief document on task-orientated teaching (the end result is to be able to do something rather than just know about it) which highly recommends role playing in family planning teaching. Outlines the content of the course, giving a timetable for a one-week course. Includes calculation of the size of the population in need and 30 case history questions for the instructor to learn about family planning. Useful.

Koba Associates Inc. (1975) Practical suggestions for family planning education.

Includes a diagram of goals, objectives and sub-objectives: p.11. and a useful checklist for setting up a family planning teaching programme: pp.14-16.

4.3.2.3.ii. Health worker roles and birth spacing training (general)

Blumhagen, R.V. and Blumhagen, J. (1974) Family health care in a rural health care delivery scheme in Afganistan.

Outlines the details of paramedical training within the overall plan of health care provision. The roles of doctors, family health workers, volunteer village health advisers, physician's assistants, nutritionists, practical nurses and laboratory assistants are described.

Cernada, G.P. and Huang, T. (1968) Taiwan; training for family planning.

India, Family Planning Association of India (no date) Family planning for nurses. 16pp.

Instructor's guide in flipbook form. Large but useful because of its good illustrations and short, clear notes.

4.3.2.3.iii. Clinics for birth spacing services

* Bamisaiye, A., De Sweemer, C. and Ransome-Kuti, O. (1978) Developing a clinic strategy appropriate to community family planning needs and practices; an experience in Lagos, Nigeria. Studies in Family Planning 9 (2-3): pp.44-48. Involving fathers in Nigeria.

* Indonesia, Directorate General of Community Health (1976) Health centre reference manual, Vol.11. Section 8: Family planning. Includes many aspects of Health Centre family planning.

* IPPF, South-East Asia and Oceania Region (1970) Starting a new clinic. Short, useful, practical booklet on how to start a new clinic.

Keeny, S.M. (1972) Improving administration in family planning; field notes.
Includes many practical suggestions for rural areas, e.g. supervision: pp.35-50, supplies: pp.50-65. Realistically assesses the possible time needed and the obstacles to be overcome in getting vehicles and materials delivered.

Korten, F.F. and Korten, D.C. (1977) Casebook for family planning management; motivating effective clinic performance. A case study of what can be done when there are too many clients at a clinic: pp.49-75. Includes four tools for making things work: targets, performance feedback, supervision, organisation of training: pp.79-82.

Nepal (1976) A working manual for clinical family planning/maternal child health activities for use by junior paramedical workers.
For teaching the administration of a maternal and child health/family planning clinic.

4.3.2.4.

Community based health and family planning overview

* El-Bushra, J. and Perl, S. (1976) Family planning education in action; some community centred approaches. Eng. Sp.
Case studies from India, Pakistan, Korea, Indonesia, Ghana, Kenya, Nigeria, Mauritius, Columbia, Dominican Republic, Costa Rica, Honduras, England.

IPPF (1973) Kirathimo model village, slides and script of MCH/FP project in Kenya. Also described in El-Bushra, J. and Perl, S. (1976) Family planning education in action; some community centred approaches. Bilingual text: Eng. Fr. Also available as cinefilm in Eng. Fr. Swahili.

* Population Reports (1982) Community based health and family planning. Series L No.3.
Special issue of Population Reports. Outlines the idea of community based distribution, reviews some of the 70 community based family planning programmes in 40 countries. They vary greatly, involving village leaders, women's clubs, traditional midwives, local retailers, local community workers.
Examines the community based distribution of other aspects of primary health care (examples of ORT; malaria treatment; worm treatment, improving nutrition, immunisation) and draws together experiences of problems in implementation. These include avoiding the overload of workers and ensuring continuing training and supervision. The best ways to organise an integrated community based distribution programme have yet to be studied.
Useful document.

* Waife, R.S. (ed.) (1981) Community based distribution of family planning supplies. No.8. Special Issue.

4.3.2.5. Fieldworker and workplace planning, organisation and evaluation for birth spacing services

4.3.2.5.i. Fieldworker and work place planning and organisation

Garnier, J.C. (1969) Morocco; training and utilisation of family planning fieldworkers. Studies in Family Planning No.47: pp.1-5.

* Hazelden, D. and Perl, S. (1975) Talking family planning; a fieldwork handbook. 94pp. Eng. Fr.

Includes suggestions for teaching in the community, and collecting general information for finding out about the community, e.g. environmental sanitation, food customs, health facilities, etc.: pp.46, 47. Also covers the questions of what to say and how to get to know an audience; administration - why organisers and supervisors need to understand management processes, getting value for money, job development and incentives; planning training - why courses fail, the use of a task orientated approach: pp.59-66; evaluation of fieldwork - when and what to do; pp.75-80. Useful.

* International Labour Organisation (ILO) (1971) Training workers as teachers and motivators of family planning. Reprint from Labour Education No.22. Eng. Fr. Sp.

IPPF (1973) Family planning; a guide to methods for fieldworkers, health, social and welfare workers. Eng. Fr. 28.pp. Reference material, written in complex English. Includes answers to the questions:

(1) Why family planning? It provides: spacing to safeguard the health of the mother and the child; protection from pregnancy until the previous baby is weaned and the mother wants another baby; the opportunity for parents to give their children a better start in life; the opportunity for parents to enjoy marriage without the fear of unwanted pregnancy; the chance for husbands and fathers to provide for the future well-being of their families.

(2) What is contraception? The pill, syringe, IUD, diaphragm, foaming tablets, condoms, sterilisation - all illustrated with good diagrams and photographs. Common questions and possible answers about the different methods are included.

(3) What do people say about family planning? Some common misconceptions are listed, with suggested replies.

IPPF (1976) Meeting the people; resource kit for training family planning fieldworkers. Eng. only. Available as multi-media kit or cinefilm.

IPPF (?1975) Population and family planning education and training materials for family welfare, social and other community service workers.

* Lesotho, Distance Teaching Centre (1976) The use of photostrips in family planning education; pretesting.

Scotney, N. (1976) Health education; a manual for medical assistants and other rural health workers. 141pp. Even the clothing of people on posters influences their

acceptability in family planning education, e.g. there are differences in what will be accepted in Dar es Salaam and Nairobi: p.8.

* **World Neighbors International** (1974) Introducing family planning in your neighbourhood; a manual for family planning fieldworkers.

4.3.2.5.ii. Fieldworkers - evaluation of birth spacing

WHO (1975) Evaluation of family planning in health services. Tech. Rep. Ser. No.569.

Health services include education and counselling on family planning; the provision of contraceptives; the management of infertility; education about sex and parenthood; and organisationally related activities, such as genetic and marriage counselling, screening for malignancy, and adoption services. The criteria for the evaluation of family planning need to be specified from the start and should include; maternal health; maternal mortality; pregnancy complications; abortion complications; obstetric complications; high parity in later child bearing years; young age at first pregnancy; short birth interval; infertility; and infant and child health (foetal mortality, perinatal mortality, neonatal mortality, infant mortality, child mortality, weight at birth, growth and development of under fives). Without such specified criteria, the evaluation of family planning is not recommended. Any evaluation must be based on needs, and include operational (plans, performance and effect) evaluation, evaluation of costs, etc.

4.3.2.6. Village health workers planning, organisation and evaluation for birth spacing services

4.3.2.6.i. Village health worker planning and organisation

* **AHEA** (American Home Economics Association) (1976) Integrating family planning and home economics. Resource handbooks, Parts I and II. Resource materials for training village level workers and for use with village people. See also Section 4.3.2.7.

4.3.2.7.ii. Village health worker evaluation

Ronaghy, H.A. et al (1976) Village health workers; proceedings of a workshop held at Shiraz, Iran, 6-13 March, 1976. Evaluation of village health worker family planning services: (1) a graph plotted of the proportion of users of oral contraception in village health workers' and control villages in Iran, and (2) a comparison of the infant mortality rate in village health workers' and control villages in Iran: pp.14-20. Useful for demonstrating the possible health benefits of family planning services, and how to assess the performance of village health workers.

4.3.2.7. TBA birth spacing services, planning, organisation and evaluation

4.3.2.7.i. TBA birth spacing planning and organisation

* Indonesia, National Workshop on Dukuns and Family Planning (1972) The role of the traditional midwife in family planning programmes, a workshop to review research.

A useful, easy to read description of the training and work of the traditional midwife, which may contain elements that would be relevant in other countries. Topics covered include:

- 1) The advantages and disadvantages of hostel-based teaching, compared with courses at family planning clinics 2-3 times per week, and with weekly courses at clinics: p.32.
- 2) Job description and an evaluation of a performance card for the Dukun as a family planning motivator: Appendices VII, VIII, IX, pp.75-83.
- 3) Aims and purposes of the training course: p.31.
- 4) Factors which may hinder Dukun training courses, illiteracy, loss of income due to course attendance, dislike of the course - and how they can be overcome - e.g. selection of Dukuns for training: pp.33-36.
- 5) Attitudes of Dukuns and others to family planning, including traditional methods of preventing pregnancy: pp.24-30.
- 6) The role and status of Dukuns in the community.

* Population Reports (1980) Family planning programs - traditional midwives and family planning. Series I, No.22. Between 60% - 80% of babies born in the third world are delivered by traditional midwives. It is now clear that traditional midwives can learn new concepts if shown in an appropriate manner. They are influential and can encourage family planning practices. Many governments are involving the midwives in family planning activities as part of maternal health work. This report includes reviews of various programmes from all over the world.

* Verderese, M. and Turnbull, L.M. (1975) The traditional birth attendant in maternal and child health and family planning; a guide to her training and utilization. WHO Offset Pub. No.18.

ii) TBA birth spacing evaluation

* Indonesia, National Workshop on Dukuns and Family Planning (1972) The role of the traditional midwife in family planning programmes, a workshop to review research. An evaluation form for Dukun family planning motivation: pp.78-83.

Peng, J.Y. et al. (1974) Role of traditional birth attendants in family planning; Proceeding of an international seminar held in Bangkok and Kuala Lumpur, 19-26 July 1974. IDRC - 039 e. Problems found and lessons learnt: pp.61-74.

* Rogers, E.M. and Solomon, D.S. (1973) Traditional midwives as family planning communicators in Asia. Case study No.1; book, cassette, script and slides. Describes why problems arose: ie. because of inadequate training and ineffective supervision. Research showed that practical,

numerous, short training were best. Tea breaks, demonstrations, field trips and role playing were all useful methods of breaking up an all day session into shorter segments.

4.3.2.8. Shopkeepers, markets and birth spacing services

* IPPF (1975) People 2 (4). Eng. Fr. Sp.
A special issue on the community distribution of contraceptives.

Thailand, Community-Based Family Planning Services (1974) New directions in family planning. 30 slides and script. 2pp.

4.3.2.9. Using local community organisations

Baybay, Ma. Lourdes (1981) Women's clubs link family planning with income generation. Family Planning International Assistance 6 (2): pp.1-3, 5.
Activities of women's clubs in the Philippines.

Indonesian Planned Parenthood Association (1972) Family planning community education manual.
Covers the organisation of community education and a three month plan of action.

IPPF (1980) Family planning handbook for doctors. 5th edition. Eng. Fr. Sp.
Chapter 16 of this book deals entirely with ways of distribution of contraceptives, e.g. advertising through an agency (local FPA) or slogans written on walls. Community based distributors (CBD) need not more than 1-2 days training. Lay workers can supply condoms and re-supply oral contraceptives for the majority of users.

IPPF (1971) The mothers' club of Sul Hwa. 16mm Film. 20 mins and accompanying leaflet. Eng. Korean. Bengali.

IPPF and American Home Economics Association (?1979) Partners in change. A multimedia pack encouraging family planning work by home economists. Including 40 slides, audio type script and a guide to use. Eng. Sp. Fr.

* Markie, J. and Perl, S. (eds) (1977) Common concern, a guide to collaborating between cooperatives and family planning associations. Education for population awareness and responsible parenthood. Eng. Fr. Sp.

4.3.2.10. Using local media and culture and developing appropriate written methods

4.3.2.10.1. Puppets as media

* Baird, B. (1971) Puppets and population.
"Effective learning is most likely to take place when educational opportunity intersects with vital daily concerns": p.5. When

puppets were first used in Germany, it was the habit of the old travelling puppet shows to send a man on a day ahead to learn what he could about the people in the villages where they were to play. By the time the show arrived it was topical and very personal. The puppeteers knew the names of the blacksmith and the baker. They knew the foibles of the mayor and his wife. All this was woven into the puppet show.

Why puppets?: After a puppet show in one Indian village, 403 people lined up to be vaccinated when they had witnessed in the play the dangers of smallpox. Puppets can say things that may be sensitive, they initiate interest and good humour rather than suspicion. Puppetry is flexible. Puppet shows can be put on anywhere with a minimum of equipment but they do require preparation, performance and follow up. Preparation - find out the history of the topic to be covered, perhaps there has been an extension programme before; find out the community resources, the influential groups, the village headman, the strong woman, the district commissioner, the health officer, etc; all these people should help determine when a play is to be given and with what emphasis.

Performance - scripts prepared as examples include: the loop (a discussion between two men), the condom, the contraceptive pill. Live local music is best for setting the scene.

Follow up - puppeteers move into the audience and start the questions because sometimes the crowd may be shy in starting talking.

East West Communication Institute (1975) Using folk media and mass media to expand communication. IEC Newsletter No.20.

* **FAO** (1967) Learning better nutrition.
Useful illustrations of puppets.

Ranganath, H.K. (1980) Using folk entertainments to promote national development. 45pp.
Potential, design, operation and evaluation are outlined.

4.3.2.10.ii. Building on local humour

IPPF (1975) Mexican humour. People 2 (3): p.40. Eng. Fr. Sp. Examples are shown of Mexican posters aimed at female passivity and male irresponsibility. The posters are part of a three stage campaign to inform the public of the scope of the demographic problem. Stage 2 aims to elicit personal commitment and Stage 3 to emphasise that the small family lives better.



Fig. 4.9: Posters hit at female passivity and (opposite) male irresponsibility.



Fig. 4.10: The slogan reads: 'Let's try for fewer so we can all live better'.

4.3.2.10.iii. Material for new literates, or simply written

Leonard, A. (1979) Sin palabras (without words). Pamphlets evaluating communication on contraceptive methods (particularly pill use) to Mexican mothers who are non literate.

Nonformal Education Information Centres, Michigan State University (no date) Annotated bibliography, Number 2. A bibliography on health education, family and child health.

4.3.2.11. Building on local beliefs and ideas

IPPF, South-East Asia and Oceania Region (1970) Misconceptions in family planning. Currently not available. Discusses ways of dealing with common beliefs about family planning.

* Abbatt, F.R. (1980) Teaching for better learning, a guide for teachers of primary health care staff. Section 2 of this book (pink) shows how to teach attitudes using examples, models, experience-sharing, discussion, and role playing.

* IPPF (Nairobi) (no date) Illustration of maize growing better when spaced. Swahili. No longer available.



Mkulima bora ye yote atakueleza hivi. Usipande mahindi yakisongamana karibu sana: yape nafasi ya kutosha ili yakue vyema: wacha nafasi ya kutosha: yatakua yakiwa na urefu mzuri na yenye nguvu. Watoto nao ni hali kadhalika: wacha nafasi ya mda ufaao kati ya mtoto mmoja hadi mwingine na utajivunia jamii yenye nguvu na afya.

IPPF: P.O. Box 30234, Nairobi, Kenya
Other versions and languages available.

Fig. 4.11.

Philippines, Family Planning Association (1975) Agricultural approach to family planning. Spaced out carrots are large and happy: close together carrots are small, thin and miserable.



Fig. 4.12: Source TCHU. This picture may be reproduced.

4.3.2.13.

Focus on youth

Edstrom, K.G. (1981) Reproductive health in adolescence: an overview. In Jelliffe, D.B. and Jelliffe, E.P. eds. "Advances in international maternal and child health", Vol.1: pp.24-42. The changing pattern of reproductive health all over the world (extra-marital sexual activity, early sexual experience or marriage, onset of menarche, early pregnancy) in the young (below 20 years) is reviewed in relation to health effects. There is suggestive evidence that maternal mortality and morbidity is higher in teenage pregnancies than in the optimum child bearing age, 20-24 years, particularly in developing countries. From studies in the Americas, mortality due to complications of pregnancy, childbirth, puerperium, or indeed abortion is ranked as one of the five leading causes of death for women 15-19 years of age. In Jamaica it was the most common cause of death, in 1971, of the age group 15-19 years. Prolonged labour was more common in the young in the Jamaican study. An increasing frequency in the young (below 20) of complications of pregnancies - anaemia, hypertensive disorders, cephalo-pelvic disproportion - is also seen in other studies. Infant and neonatal mortality were also found to be higher in the teenage group than in any other age group. Socio-economic factors play an important role. Infant mortality due to nutritional deficiency is higher in teenage mothers than for any other age group, as shown in the Americas. Low birth weight is also more likely in teenage mothers. Induced abortion is likely to be later (second trimester) in the teenage group than older ones, with the overall health risk being greater.

The social implications of teenage pregnancy include: dropping out from school; more unemployment; more lost jobs; more divorce; than women who get pregnant in the 20-24 age group. A host of actions can be taken: better antenatal care, provision of contraceptive services, discouraging early pregnancy, legal measures specifying lower limits of marriage, liberal abortion laws etc.

* **Family Planning Association, UK** (no date) Don't rush me; Too great a risk. 2 cartoon leaflets. Useful.

Grapevine Project, Family Planning Association, UK

A programme aimed at young people via fieldworkers in places young people go e.g. pubs, etc. Details In El-Bushra, J. and Perl, S. (1976) Family planning education in action, some community centred approaches.

UNESCO (1972) (Agricultural approaches) in educational programmes in rural areas by C.S. Brembeck and R.L. Hovey. Document SC/WS/507.

* **Guild of Health Education Officers Ltd.** (1980) Growing up for boys. (Growing up for girls is also available).

* **Health Education Council, UK** (?1982) Answering a child's questions on growing up.

Hemming, J. (no date) Teenage living and loving. 30pp. A UK booklet with many cartoons which explains to teenagers the working of their bodies and coping with personal problems in adolescence, e.g. family relations, friends, love experience.

* **IPPF** (1975) Where next? Youth and family planning. Currently not available. Includes a wide variety of ideas for action, including records, songs, concert promotion and pop festivals.

* **IPPF** (1978) Adolescent sex; its difficulties and dangers: an outline for clinic personnel, parents and teachers. Eng. Fr. Includes amusing illustrations.

* **IPPF** (1975) Reaching out of school youth, a project planning handbook for population - family life education. Eng. only.

* **Lifeline** (no date) Interpersonal relations teaching for secondary schools. Includes illustrated cards depicting typical problem situations experienced by adolescents, for use in discussions. (These problems were identified in a research project preceding the development of the teaching materials). Very useful as a model for developing appropriate methods of teaching.

4.3.2.14.

School curricula

See Section 4.3.2.16. Use of mass media.

* Reid, D. and Booth, P. (1971) How life begins. Biology for the individual, Book 2.
Intended for UK Secondary Schools: covers not just conception and growth in utero, but also changes at puberty. Very useful for adolescents.

4.3.2.15.

Workers' education

International Labour Organisation (ILO)

Publications:

- Population and family welfare education for workers; a resource book for trainers. 64pp. 1980.
- L'education du bien-etre familial et la population par l'image. Project RAF/76/PO2 Travail et population pour l'Afrique. 88pp.
- Family planning in industry in the Asian Region Part 1. The manual. 52pp. Revised 1977.
- A series of 5 questions and answer booklets (general). In preparation.
- Handbook on population and family planning for labour leaders. To be completed.
- Training workers as teachers and motivators of family planning. Reprint of article on Labour Education. No.22 1971. Eng. Fr. Sp.
- Reports and preceedings of Regional Seminars mentioned in the Bulletin of Family Planning Reviews No. 2 are available.
- The rising tide: the ILO looks at the population problem. 1974. Eng. Fr. Sp.

Audio-visual aids:

- Let's face our future! 1974. Flannel set. Eng. Fr.
- Kits of workers' population education materials. Prepared by CBWE in collaboration with ILO Labour and Population Team, Bangkok, 1973.
- Series of flannel symbols for use in workers' and/or co-operative population education in Africa. 1974.
- Similar flannelgraph materials for Asia.
- Hard-up Joe. Comic book, filmstrip on the role of trade unions in family welfare. For use in the Caribbean. 1974.
- Flip-chart, The stake of workers in populations questions. Revised August 1972. Eng.
- Flipchart - A vous de juger, with accompanying booklet. Fr. 1973.
- Two flip-charts for Asia (one based on a series of Indian myths, one looking at population growth in Asia).
- Film - It can be done (Barbados). Made in Caribbean for use by workers' organisations, educators etc. 1973.
- Film - They call it Griha Pravesh. The film describes the Aurangabad project in India. 1974.

* Berrigan, F.J. (1977) A manual on mass media in population and development. UNESCO Population Communication Manuals. Many languages.

Outlines planning, organisation, production and evaluation.

BBC Radio for Schools (1976-1977) Learning about life. 24pp. A series of programmes made in 1976 and 1977 for schools. Deals with all aspects of adolescent life in a simple way. Many line diagrams.

BBC TV (1977) Merry-go-round: Sex education. BBC. An excellent pamphlet for teachers giving the summary of the TV programmes (3 in all) and a follow up to the programme.

Grampton-Smith, G. and Curtis, S. (no date) Longman Thinkstrips: Teacher's notes.

A series of notes and well illustrated filmstrips. The titles include: (1) Too great a risk (pregnancy), (2) Don't rush me (marriage).

International Labour Organisation (ILO) (1976) Time for transition. Comic booklet and animated cartoon film. 13 mins. Colour and sound. 16 mm. Eng. Fr. Sp. Focuses on the 700 million people living in acute poverty: at least 400 million are suffering from malnutrition; nearly 300 million in the developing countries alone are unemployed or underemployed; the poor are steadily losing ground in the struggle for social and economic progress.

International Labour Organisation (ILO) (1976) 300 million people. Film and comic booklet. Film 10 mins. 16 mm. Eng. Fr. Sp. Arabic. Focuses on the 300 million new work seekers expected in the next decade.

Keating, R. (1977) Grass roots radio - a manual for fieldworkers in family planning. Book and cassette. Eng. only.

UNESCO (1975) Population communication technical documentation. Many languages.

No.1 Communication media, family planning and development.

No.2 Communication research in family planning, and analytical framework

No.3 Research in population communication. by Feliciano, G.D. (includes pre-testing, case study methods, survey methods, experimental methods).

edition. Eng. Fr. Sp.

Chapter 9 of the book is devoted to menstrual regulation. The preparation and counselling of the patient and the operative procedure are explained. The problems related to menstrual regulation are discussed, such as: failure (1 in 50 aspirations fail to evacuate the conceptus); side effects (such as convulsions owing to a sensitivity to local anaesthetic; or infection); redundant operations on women who fear that they were still pregnant after the procedure.

* Kleinman, R.L. (ed.) (1976) Male and female sterilisation. Menstrual regulation. 2nd. edition. Eng. Fr. Sp.

* Pion, J.R. and Hale, W.R. (1975) Aspiration curettage for menstrual delay. Reprint from Gynaecology and Obstetrics Vol. III, Chapter 42.

A simple well illustrated step by step introduction to the method.

4.4.2.11.

Abortion

Boston Women's Health Book Collective (1979) Our bodies ourselves; a book by and for women.

Chapter 11 reviews some of the legal aspects of abortion. The authors contend that the psychological effects of voluntary legal abortion are frequently good. Since the introduction of legal abortion, infant mortality and maternal deaths related to illegal abortion have declined. The various methods of legal abortion available are described for women to decide which they prefer.

Brent against Corrie Pamphlet Group. (1980) Mixed feelings. 10 women tell about their experience of accidental pregnancy and abortion. The situation of each woman is different. Jill who had four children already, decided to seek an abortion when her cap failed for the third time. Anne learnt the horrors of backstreet abortion as a student nurse. Jenny became pregnant despite having a coil. The family planning clinic told her she had influenza. The women speak about how they became pregnant, how they came to their decision about having an abortion, their experience with doctors and clinics and their feelings throughout.

Flavier, J.M. and Chen, C.H. (1980) Induced abortion in rural village of Cavite, the Philippines: Knowledge, attitudes and practice. *Studies in Family Planning*. 11 (2): pp.65-71. A survey was conducted by the International Institute of Rural Reconstruction (IIRR), in five rural villages. One of the objectives was to assess public awareness of abortion. Of the reported abortions, TBAs provided 32%, physicians and drugstores 29% each. 12% of the interviewees were hospitalised due to complications from abortions.

* **IPPF** (1980) Family planning handbook for doctors. 5th edition. Eng. Fr. Sp.

Chapter 10 of this book deals with the legal and technical problems of abortions. The section on emotional effects of abortion stresses that while women who were physically and

mentally undisturbed before the abortion show little or no after effects, women who were emotionally upset before abortion may still continue to be so after abortion. However, having late abortions may have adverse effects psychologically, not only for those women who had not fully decided to have an abortion, but also those with a cultural upbringing that induced guilt on abortion. Abortion counselling is thus felt necessary both before and after abortion.

* Kleinman, R.L. (ed.) (1984) Abortion; classification and techniques. 2nd edition. Illustrations, graphs, tables and bibliography.

This booklet defines the various types of abortion, and describes the rapid advances taking place in the surgical technique of terminating pregnancy. Administration and contraceptive advice after termination are also discussed.

Patient Care Publications (1979) Patient care flow chart: Explaining the options of abortion type, and treating complications of abortion. (Flow diagrams).

* IPPF (1978) Abortion. People 5 (2). Eng. Fr. Sp.

A whole issue of the journal 'People' devoted to the subject of abortion. It includes case studies of women who have had abortions (legal and illegal), and country reports from Italy, and from Chile, one of the few countries which has researched abortion closely. In Chile, from 1967-1972, there was a steady decline in abortions and also a decline in maternal mortality. The Indian experience is also reviewed, where results remain to be seen, despite the liberalisation of the law. There is an extended report from Vietnam, where a strenuous effort was made by the Government and health workers to introduce family planning all over the country, particularly in the south. It is very likely that Vietnam, like the East European countries will continue to use abortion as a method of fertility regulation.

IPPF (1976) Abortion available to most women. People 3 (2): pp.30-31. Eng. Fr. Sp.

Although the most important reason for liberalising laws of abortion is: to combat illegal practices, the lack of personnel and facilities and the attitudes of the medical profession may restrict women's access to abortion. This article was prepared from a report of the Population Council's 1975 fact book on induced abortion. The report notes that the majority of abortions are performed on women aged 20-29, although the proportion of women under this age seeking termination is increasing. The most important result of liberal abortion policies is that maternal mortality decreases as the number of legal abortions rises.

IPPF (1976) Abortion: obstacles to truth. People 3 (4): p.33. Eng. Fr. Sp.

An article based on the Population Council's study in Latin America. The combined weight of tradition, prejudice, religion, the low status of women and other moral and legal sanctions are the major obstacles to collecting correct data about the incidence of abortion in Latin America. Women who used contraceptives had 27% more abortions than non-users. Similar data was reported from

CHECK LIST FOR GIVING FAMILY PLANNING PILLS
(Eugynon ED Fe and Microlut)

Before the aid post orderly gives pills to a woman he should ask her these questions -

Write "Yes" or "No"

- 1. Has she had yellow eyes or yellow skin in the last year?
(Look at her skin and eyes to see if they are yellow now)
- 2. Has she a lump in the breast?
- 3. Has she blood stained discharge from the nipple?
- 4. Does she have bad headaches?
- 5. Has she got big veins in her legs?
(Look at her legs to see if she has bad varicose veins)
- 6. Does she lose too much blood with her menstrual periods?
- 7. Do the menstrual periods come too often?
- 8. Is she breast feeding a baby less than 12 months old?
(If "yes" to question 8 - give her Microlut pills)

If the woman answers "no" to all questions, the aid post orderly can give her the pills.

If any are answered "yes" (except Q.8) she should be referred to a sister or doctor first.

Fig. 14.4.

Roleplays

(examples of women who ask for pills)

The aid post orderly (APO) reads through the check list.

Mrs. A. answers:

To question 1: "Yes. A month ago I had yellow eyes, my skin was itchy and my urine was brown like tea."

To questions 2 to 8: Mrs. A. answers "No".

The APO has to think about his advice to Mrs. A.

(Answer: She must not have pills yet. She should use some other method of family planning for a year).

Mrs. B. answers:

To questions 1 and 2: "No".

To question 3: "No, but I have blood when I cough. I have had a bad cough for 2 months, and now I have started to have injections for TB."

To questions 4 to 8: "No".

What does the APO advise?

(Answer: She can take the pills).

Mrs. C. answers:

To questions 1 to 3: "No".

To question 4: "No, I don't have headache but my head goes round and I feel very weak and tired.

Questions 5 to 8: "No".

What does the APO do?

(Answer: He looks at her eyes and mouth and tells her, "I think your blood is weak. You have anaemia. You need medicine for this. But you can take the pills for family planning.")

Mrs. D. answers:

To questions 1 to 6: "No".

To question 7: "Yes, I have menstrual periods two times every month."

Question 8: "No".

What does the APO do?

(Answer: The APO replies: "I can't give you the pills. First you must go to a sister or doctor for a vaginal examination.")

Table 4.1.

* Scottish Health Education Group (no date) Male and female sterilisation: a guide to help you make the decision.

Stokes, B. (1977) Filling the family planning gap. Worldwatch Paper 12.

The author concludes that there is no single way to fill the family planning gap. Each country must find its own path, designing programmes that are appropriate to the cultural, political, and economic realities it faces.

* US, Dept. Health Education and Welfare (1976) Female physical examination for contraception.

* Wagatsuma, T. and Wagatsuma, M. (1979) Overall scheme for examining the advantages and disadvantages of different methods of fertility regulation.

Werner, D. (1977) Where there is no doctor.
See also Section 4.4.2.6.
pp.284-294.

Several methods of birth control are described "Some work better for some people than others. Study these pages, and talk with your midwife, health worker, or doctor about what methods are available and are likely to work best for you. Differences in effectiveness, safety, convenience, availability, and cost should be considered. Husbands and wives should decide together, and share the responsibility...."






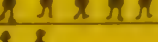

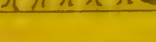






Of each 20 women using this method . . .	on the average this many are likely to get pregnant in spite of the method . . .	and this many must (or should) stop the method because of problems.
PILL		
CONDOM		
DIAPHRAGM		
FOAM		
I. U. D.		
PULLING OUT		
STERILIZATION		*
SPONGE		
RHYTHM		COMBINED 
MUCUS		

Fig. 4.15.

"A woman who has any of the following signs should not take oral (or injected) contraceptives:

Deep or steady pain in one leg or hip

This may be caused by an inflamed vein (phlebitis or blood clot). Do not use birth control pills. (Women with varicose veins that are not inflamed can usually take birth control pills without problems. But they should stop taking them if the veins become inflamed).



Fig. 4.16 a

Stroke

A woman who has had any signs of a stroke (p.237) should not take the pill.



Fig. 4.16 b

Hepatitis (p.172), cirrhosis (p.238), or other liver disease
Women with these problems, or whose eyes had a yellow colour during pregnancy, should not take the pill. It is better not to take oral contraceptives for one year after having hepatitis.



Fig. 4.16 c

Cancer

If you have or suspect cancer of the breast or womb, do not use oral contraceptives. Before beginning oral contraceptives, examine your breasts carefully (see p.279). In some health centres you may also be able to get a simple test (Pap smear) to check for cancer of the cervix or opening of the womb. Birth control pills do not cause cancer, but if cancer of the breasts or womb already exists, the pill can make it worse."



Fig. 4.16 d

* Werner, D. and Bower, B. (1982) Helping health workers learn.

The problems of family planning: Chapter 23. "Those who promote population control do not always inform people adequately about the risks, and on the other hand those who oppose population

control may exaggerate the risks. Even those who object to certain family planning methods for religious reasons sometimes find it easier to influence people with the fear of cancer than with the fear of God. In the political battle over birth control the wishes of the poor are often forgotten".: p.23-1.



Fig. 4.17: Political battle over birth control, the wishes of the poor are often forgotten.

4.4.2. Methods of birth spacing

4.4.2.1. Social policy - late marriage etc.

Akhtar, Shahid (1975) Health care in the People's Republic of China; a bibliography with abstracts. IDRC-038e.

* Chen, P. and Kols, A. (1982) Population and birth planning in the People's Republic of China. Population Reports. Series J. No. 25: pp.J577-620.

Ellis, E.O. (1973) Status of women in China: maternal and child care. Journal of the National Medical Association (New York) 65 (1): pp.24-26.

Emphasises the importance of the improved status of women in society; particularly in education, nutrition, work load and income.

Muchua, C. (1979) Birth planning in China. International Family Planning Perspectives 5: pp.92-100.

Potts, M. (1972) Models for progress; United Kingdom (1919-1939) and China People's Republic (1957-1971). New concepts in contraception: a guide to development in family planning. A comparative study which would be useful for planners. The objectives are clearly defined.

Boston Women's Health Book Collective (1979) Our bodies ourselves; a book by and for women.

Chapter 10 deals with birth control. The approximate failure rate of lactation as a control method for 12 months is given as between 25-40%. (Other items of family planning deal with in this chapter include: abstinence, hysterectomy, tubal ligation vasectomy, oral contraceptives, intra-muscular injections, condoms, IUD, diaphragm, coitus interruptus, rhythm, and lactation. The advantages and disadvantages of each are discussed).

* **Population Reports** (1981) Breastfeeding, fertility and family planning. Series J No.24.

Senanayake, P. (1981) The role of lactation in delaying conception. In: Wallace, H.M. and Ebrahim, G.J. Maternal and child health around the world. Chapter 12: p.127.
For reference.

Van Ginneken, J.K. (1974) Prolonged breastfeeding as a birth spacing method. Studies in family planning 5: pp.201-206.
Useful reference material.

* **Werner, D.** (1977) Where there is no doctor.

"While a woman is breastfeeding her baby she is less likely to become pregnant, especially when breastmilk is the only food her baby receives. The chance of her becoming pregnant is much greater after 4 to 6 months, when the baby begins to get other foods in addition to breastmilk. To be sure she will not become pregnant, the mother who is breastfeeding should begin some method of birth control when the baby is 3 to 4 months old. The earlier she begins the surer it will be. (Before the baby is 6 months old, a method other than birth control pills is better because some pills cause some women to produce less milk)": p.292.

There is always some time postpartum before sexual relations are resumed. In many societies this is a clearly defined interval of perhaps two years. It is said in some places that fathers should wait until the child can hold on to the father's fingers to be lifted out of his cot.

* **Boston Women's Health Book Collective** (1979) Our bodies ourselves; a book by and for women.
Chapter 10: Birth control. The withdrawal method is not recommended because it has a pregnancy rate of 20-30%. The man must be responsible and the woman cannot relax. Despite this, withdrawal is the most universally used of all methods in many countries. Couples who have used it for a long time may be able to solve some of the problems related to withdrawal.

Barrier methods (including herbs)

* Family Planning Association, UK (1970) Family Planning Association clinic handbook.

Loose-leaf so that it can be kept up to date by inserting additions.

* Howard, G. (1976) Methods of family planning.

24 slides with text, explaining each method by means of questions and answers. Contraceptive methods such as withdrawal methods, use of the condom, the pills, injectables, Lippes loops are well explained. The physiological basis for using hormonal (pill) methods is described. The rationale for birth spacing/family planning (maternal mortality, infant mortality) is explained at the beginning. A cassette tape is also available.

IPPF (1981) Directory of contraceptives. 3rd edition. Eng. Fr. Sp.

Describes the composition of all contraceptive materials, and gives the results of tests on spermicides carried out by IPPF 1971-1975.

IPPF (1973) Family planning; a guide to methods for fieldworkers, health, social and welfare workers. Eng. Fr. 28pp.

* IPPF (1980) Family planning handbook for doctors. 5th edition. Eng. Fr. Sp.

* IPPF (1976) Family planning handbook for midwives and nurses. 2nd edition. Eng. Fr. Sp.
For reference only, not an easy book to read.

* IPPF (1977) Introducing contraception. Eng. sp. 16pp.

* IPPF (no date) Simple guide to methods of family planning. No longer available.

Includes a useful section on home-made barriers and spermicides, pointing out that home-made versions are cheaper than, but not as effective as other methods of contraception. Homemade barriers will be safer if used with a manufactured spermicide.

"How to make barriers"

1. Vaginal Pads.

Cut a clean, soft thin cloth into pieces about the size of two hands. The cloth need not be new, but must be well-washed. Fold it with the frayed edges inside and attach a strong thread to hold it together and to help with its removal after use.

2. Sponges.

Use a small sea sponge, or cut the shape and size required (that of a hen's egg), from foam rubber latex or plastic material. Attach a strong thread to help to remove after use.

How to make spermicides

1. Mix one part vinegar or lemon juice with 20 parts of warm boiled water.
or
2. Dissolve a cube ($1\frac{1}{4}$ - $1\frac{1}{2}$ oz) of plain pure soap in a quart (litre) of warm water that has already been boiled. Strong soaps (e.g. carbolic) or soap powders and detergents must never be used.
or
3. Use any sweet or cooking oil (except mustard oil), or any fat (including butter and margarine).

How to use home-made barriers and spermicides

1. Dip the pad or sponge into the spermicide and squeeze until it stops dripping. If you use oil, it is only necessary to smear it on the outside of the barrier.
2. Place the pad or sponge as high as possible in the vagina a short while before intercourse takes place. You can do this most easily in the squatting position.
3. About 8-10 hours after intercourse remove the barrier.
4. Do not douche before you remove the barrier: if you want to douche, wait for eight hours after intercourse.
5. Wash barriers made of cloth or sponge in soapy water; after rinsing them in clear water put them away in a clean rag or handkerchief."

Nadim, Nawal El Missiri (1980) Rural health care in Egypt. IDRC - TS 15e

A study of the work and attitudes of the Daya (traditional birth attendants) in 4 village communities of rural Egypt. Describes the use of aspirin (inserted into the vagina presumably for its acidic effect) and the swallowing of castor oil as contraceptives.

Pan-American Federation of Associations of Medical Schools (1975) The teaching of family planning in the medical school. Lists the contents of lessons to cover specific objectives. Many of the lessons are too complex for village workers, but pp.21-77 might be useful for learning how to list the broad contents of the topics the village workers are to cover: e.g. the effects of family planning on health: p.23; the health worker's role in family planning: p.23; modes of action of different oral contraceptives: p.57; the long and short term effects of oral contraceptives: p.59; clinical criteria for prescribing oral contraceptives: p.61; and profiles of candidates for different contraceptives - pill: p.61; IUD: p.63; mechanical and chemical methods: p.67; rhythm: p.69.

* **Population Dynamics** (no date) Proud Pete (flip me back to front): to make the condom easier to talk about, prevent disease, to teach correct use of the condom, and to make people smile! A cartoon booklet to be read through quickly.

Strikes, B. (1980) Men and family planning. Worldwatch Paper 41.

"Men are the forgotten sexual partners ---- male contraceptives

are treated as second class birth control methods; stores persist in hiding them under counters, and in many countries their advertisement is banned and there has been little research into new male methods of birth control."

* VHAI (no date) Modern methods of family planning. Flannelgraph.

Walt Disney (no date) Family planning Film. In 25 languages.

* Werner, D. (1977) Where there is no doctor. A sponge method (plus vinegar, lemon juice or salt) is described and illustrated. It will not necessarily prevent pregnancy but it can be used when no other method is available: p.292.

* WHO (1974) Illustration bank. Drawings for use in teaching include: condoms (p.56); a diaphragm being placed over the cervix (p.57); applying spermicidal cream to the diaphragm (p.58).

4.4.2.6. Hormonal methods

4.4.2.6.i. Pills

Costa Rica, Programa Nacional de Planificacion (no date) La pastilla.

IPPF (1978) About the pill. Eng. Fr. Sp. Port. Arabic.

Kleinman, R.L. (ed.) (1973) Systemic contraception. 86pp. Eng. Fr. Sp.

Mexico, Coordinacion del Programa Nacional de Planificacion Familiar (1977) La pastilla anticonceptiva. Sp. A brochure that can be used for illiterate and semi-literate village people.

* Papua New Guinea, Dept. Public Health (1975) (1) Family planning for aid-post orderlies and nurse aides. 35pp. (2) Guide for teachers of aid-post orderlies and nurse aides. Lesson 8: Good and bad points of pills, including common side effects and what to do about them. There are some good side effects.

"Good points" - reasons why women like the pills.

1. They are safe for Papua New Guinea women, much safer than having a baby.
2. They work very well in preventing pregnancy if none are forgotten.
3. Women can get pregnant when they wish. (When a woman wants to become pregnant she stops taking the pills after she finishes a packet).
4. There is nothing to do just before having sexual intercourse.
5. They are fairly cheap.

6. There is usually less menstrual bleeding - anaemia is less likely.
7. They can be used by women who have never had a baby (compare with Lippes loop).
8. They can be given without a vaginal examination (although it is better for nurses to do it if the patient agrees).

Bad points

1. Women must remember to take a pill every day.
2. The pills must be taken in the right order.
3. Women have to get new supplies of pills.
4. There may be side effects at first.
5. There may be a little less breast milk with Eugynon ED Fe, so Microlut should be given to women breastfeeding a baby less than 12 months old.
6. The pills must be started at the beginning of the menstrual cycle. They do not prevent pregnancy straight away if they are started at other times."

Philippines, Family Planning Association (no date) Casebook on oral contraceptives.

Case studies for use in teaching, asking the question "what would you do?"

* **Philpott, R.H. et al.** (1977) Obstetrics, family planning and paediatrics: a manual of practical management for doctors and nurses.

A well laid out manual, easy to use for reference. Each section starts with a large black dot and a bold heading so it can be seen easily. The family planning section includes list of questions to ask potential pill patients: p.59.

Sunday Times Magazine (1968) Living with the pill and other methods of contraception. What every man and woman needs to know about birth control.

A question and answer guide to contraception.

* **Werner, D.** (1977) Where there is no doctor.
pp.288-289: Illustrates contra-indications to the pill and questions and answers about birth control pills.

WHO (1982) Oral contraceptives. Technical and safety aspects. (WHO offset publication No. 64) Eng. Fr. (Sp. version, PAHO publicacion cientifica No. 428).

Questions and Answers about Birth Control Pills



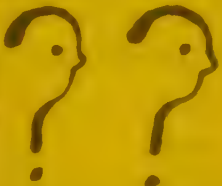

	Some people claim birth control pills cause cancer. Is this true?	No! However, if cancer of the breast or womb already exists, taking the pill may make the tumor grow faster.
	Can a woman have children again if she stops taking the pill?	Yes. (Sometimes there is a delay of a month or 2 before she can become pregnant.)
	Is the chance of having twins or defective children greater if a woman has used oral contraceptives?	No. The chances are the same as for women who have not taken the pill.
	Is it true that a mother's breasts will dry up if she starts taking birth control pills? For this reason it is a good idea for women who are breast feeding to use another method of birth control during the first 6 months, and then change to the pill.	Most women are not affected. But some mothers produce less milk, or stop making it altogether, when they start taking the pill.

Fig. 4.18.

4.4.2.6.ii. Injectables

* Papua New Guinea, Dept. Public Health (no date)

A set of family planning education materials including a poster: "The family planning injection can be used by women with four children". Also contains a flip chart on the use of pills.

4.4.2.7. Intrauterine devices

See also the IPPF publications in Section 4.4.2.5. Barrier methods. Many of the manuals also cover IUD.

* Kleinman, R.L. (ed.) (1977) Intrauterine contraception. 4th edition. Eng. Fr. Sp.

* WHO (1974) Illustration bank.

Includes: Lippes loop in place p.61, and the introducer and plunger p.62.

World Neighbors International (no date) Family planning: the pill; Family planning: the IUD. Filmstrips. Eng. Sp.

4.4.2.8. Surgical

Birmingham Pregnancy Advisory Service, UK (no date) Vasectomy.

Booklet for parents.

The booklet is written for parents intending to use vasectomy as a contraceptive method. It is simple and well written.

Carolina Population Centre (no date) Vasectomy; tying the man's tubes, a permanent method of birth control.

A good example of a small booklet but the English used is complex.

* **Scottish Health Education Group** (no date) Male and female sterilisation - a guide to help you make the decision.

A six page leaflet with diagrams of the male and female reproductive organs and the positions for surgical intervention.

US, Dept. Health, Education and Welfare (1978) A male sterilisation procedure.

This is a self-instructional booklet for men, to help them understand about vasectomy. It is well illustrated and written in simple English.

US, Dept. Health, Education and Welfare (1978) Understanding female sterilisation.

A self-instructional booklet to help women understand the procedure. It is well illustrated and presented in a step by step manner.

* **WHO** (1974) Illustration bank.

Drawings for use in teaching. They include: a vasectomy operation p.54; vasectomy p.55; uterus/uterine tube/ovary/cervix/vagina p.60.

4.4.2.9.

Rhythm

Family Planning Information Service (no date) The rhythm method -The safe period.

A leaflet which shows how to calculate and graph one's own safe and unsafe days into charts. The calendar method and the temperature method are explained in a simple manner.

IPPF (1980) Family planning handbook for doctors. 5th edition. Eng. Fr. Sp.

A combination of basal body temperature to detect ovulation and the "peak symptom" - mucus which appears at the external os of the cervix can be recognised by women themselves. The rhythm method demands high motivation.

* **Population Reports** (1981) Periodic abstinence: how well do new approaches work? Series I No.3: pp. I 33-72.
Describes the cervical mucus method in detail.

* **Werner, D.** (1977) Where there is no doctor.
The rhythm method explained in a simple way.

4.4.2.10.

Menstrual regulation

* **IPPF** (1980) Family planning handbook for doctors. 5th

4.4. Counselling on choice of methods for birth spacing/family planning

4.4.1. Choosing a method of birth control

Birmingham Pregnancy Advisory Service, UK (no date) Vasectomy booklet for parents.

* Boston Women's Health Book Collective (1979) Our bodies ourselves, a book by and for women.

Chapter 10: Birth control. Includes a rationale for choosing a contraceptive, based on failure rates and the effectiveness of the method. The pill ranks as the most effective, with the lowest chance of conception. The withdrawal method, vaginal tablets and suppositories, douching are not recommended. Indications for those who should not take the pill are explained.

Ghana, University of Ghana Medical School (1977) Family planning manual for health workers.

Emphasises (p.14) that to help people make best use of family planning, health workers should tell them how the methods work and the advantages and disadvantages of each method. Has a very useful section on "dispelling fears and rumours about family planning", listing common fears and how to dispel them.

"Ideal requirements of a contraceptive

1. It ought to be harmless to either partner, and must not affect any future offspring who might be born as a result of failure of the method, or on stopping the use of the method.
2. It must be reliable, so that protection against pregnancy can be guaranteed if instructions are carried out properly.
3. It must be acceptable. It should be simple, practical and pleasant to use, and should not interfere with the sex act.
4. It should be cheap enough to be within the means of everyone, especially the poor who need it most.
5. It should be reversible, so that when the couple are ready to have another baby, they can have one....."

"Failure of a method

This may be due to:-

Method failure	- unreliable.
Patient failure practice	- ineffective contraception practice.

The usual causes of failure are:-

1. Failure to understand the method properly.
2. Failure to use the method consistently - "Taking a chance" whether through forgetting, or running out of supplies, or finding it too much trouble.
3. Carelessness.
4. Accidents can happen - e.g.: leaking from a condom as it is removed or if there is a tear.
5. Misunderstanding between a couple, each thinking the other is taking the responsibility.

6. In some cases, there does not seem to be any apparent cause for failure, and it would appear that it is a method failure - however, careful questioning might reveal that there has been a patient failure e.g.: some women stop taking their pills when the husband goes away on a short journey".

JOICFP (1977) Magnet 77: Magnetboard teaching material on family planning.

The most common contraceptive methods, with an explanation of the advantages and disadvantages of each.

King, M. (ed.) (1966) Medical care in developing countries.

Table 10: Family planning methods compared: section 18.8.

Lists the effectiveness and annual cost in East Africa of eight methods.

FAMILY PLANNING METHODS COMPARED				
Non-Medical Methods	Sex	Effectiveness	Annual Cost	
			Shs. E.A.	\$
Disposable condom	Male	Very effective	100/-	14.40
Reusable rubber sheath	Male	Good	100/-	14.40
Vaginal cream (and applicator)	Female	Fair	90/-	12.50
Vaginal foam tablets, etc.	Female	Poor.	46/-	6.50
The Rhythm method	Variable	effectiveness, depends upon menstrual regularity, careful record keeping and self-discipline		Nil
Coitus interruptus	Male	Unreliable		Nil
Medical Methods				
Diaphragm plus spermicidal cream	Female	Very effective	diaphragm 11/50 cream 90/-	1.50 12.50
'The Pill' or oral anovulatory tablet	Female	Very effective	84/6	12.00
The 'IUD'	Female	Very effective	1/-	0.14

Note:—Medical methods require the advice of a doctor or a midwife and some need fitting, non medical methods do not.

Fig. 4.13.

* Papua New Guinea, Department of Public Health (1975) Guide for teachers of aid post orderlies and nurse aides. No longer available.

In a lesson by lesson format for each method, includes a list of common side effects and their frequency and what to do about difficult ones. The guide is simply and clearly written and laid out. It includes a sample family planning pill card with key questions to ask to identify contraindications for oral contraception.

Chile, where induced abortion occurred more frequently among women who use contraceptives.

Husberg, K. (1977) Family planning halves abortions. *People* 4 (1): p.29. Eng. Fr. Sp.

A research report from the Swedish island of Gotland (pop. 54,000) in the Baltic Sea. Before 1974, the abortion rate for Gotland was 19 per 1000 women between the ages of 14-44 years, almost equal to Sweden's big cities. The islanders, a farming community, had conservative attitudes and services were inadequate. A project was launched by the Swedish Government to increase the family planning services, and the local nurse and midwives conducted a campaign of discussions, lectures and films.

Van der Does, C.D., Haspels, A.A. and Lambers, M.D.A. (1984) *Obstetrics and gynaecology in basic health services*. Chapter 4: Vaginal blood loss in the first half of pregnancy. Discusses the management of threatened, missed or incomplete abortion.

4.4.2.12. Cultural factors (shame)

Indonesia (1978) Shame is the best contraceptive. *Economist*, November 25th: p.74.

Describes the shadow play theatre stories in which village culture has been "harnessed" to promote change. People laugh at the puppets who have too many new babies and who hang their heads in shame. In Bali, it is said, each village pavilion has a well displayed map. Pill users are shown by red houses, IUD users by blue houses, condom users by green. The houses of non-users, which are left blank, are said to bear something of a social stigma.

Lovel, H., Mkandla, M. and Morley, D. (1983) Birth spacing in Zimbabwe a generation ago. *Lancet* 2: pp.161-2.

It is reported that, in Zimbabwe a generation ago, children born too close together were considered to show carelessness on the part of the man.

4.5. Infertility/subfertility

4.5.1. Teaching how babies come to be conceived and born

* Guiry, N.N. and Thompson, C. (1964) *Human reproduction and planned parenthood*.

Flipbook on the human reproductive process for the local community.

IPPF (1971) *The use of pelvic models in family planning programmes*. 18pp.

Describes six models and assesses: their appropriateness for demonstrating particular family planning methods to specific audiences; and their suitability for field work e.g. the accuracy of the anatomical modelling and whether the model tends to come apart.

* JOICFP (1977) Magnet 77: Magnetboard teaching material on family planning.
Magnet board teaching material with excellent illustrations rather than the diagrams usually found which are less easy for village workers to understand. Expensive but easy to use in rural areas.

* Maternity Centre Association (no date) How to make a knitted uterus for teaching.
Excellent. In use in many countries.

Malaysia, Federation of Family Planning Associations (1972) Your body and family planning. 63pp.
Describes looking at anatomical diagrams as being similar to seeing the inside of a chilli pepper. Taking the pill is like the dissolving of sugar or putting salt in food.

* Mayle, P. (1975) What is happening to me? A guide to puberty - for teachers.

* Mayle, P. (no date) Where did I come from? A guide to conception and birth - for teachers.

Murphy, W.E. and Quadland, M.C. (1972) Human reproduction and family planning; a programmed text. 128pp.
Includes a diagram of hormone levels in the normal menstrual cycle: pp.74, 75.

* Reid, D. and Booth, P. (1971) How life begins. Biology for the individual, Book 2.
Written for UK secondary schools.

4.5.2.

Taking action on subfertility

See the Rhythm (safe period) method of contraception in any reference text book (e.g. WHO (1974) Illustration bank: p.59., and Pan American Federation of Associations of Medical Schools (1975) The teaching of family planning in the medical school). Use the information there to help people who wish to conceive rather than to prevent conception. Sexual relations should then take place midway between menstruation, on the 'unsafe' days. See also the Mucus method of contraception (in e.g. Werner, D. (1977) Where there is no doctor: p.294.) Use the information there to help people who wish to conceive. If pregnancy is desired then sexual relations should take place when the mucus is slippery or stretches.



Fig. 4.19: The mucus method.

Source: Werner, D. (1977) Where there is no doctor.

Afghanistan, Ministry of Public Health (1977) Basic health centre manual.

Contains a useful flow chart on subfertility/infertility management.

* Guest, I. (1978) Special Report: Infertility in Africa. People 5 (1): pp.23-34. Eng. Fr. Sp.

The IPPF sent a reporter to Africa to describe the problem. He visited Kenya, Tanzania, Zaire, Uganda, Cameroon and studied the problem of infertility after talking to professionals (gynaecologists) and traditional healers. His report covers primary infertility (the women who have never conceived before), secondary infertility (women who have conceived on a previous attempt but not subsequently), and subfertility.

IPPF (1980) Family planning handbook for doctors. 5th edition. Eng. Fr. Sp.

Chapter 12 of this book contains a useful introduction to infertility: the causes of infertility in men and women, the investigations needed to be done in both, and possible treatment. It needs simplifying and adapting if it is to be used by local community health workers in family health.

* IPPF (1979) Handbook on infertility. Eng. Fr. Sp.

A useful overview for reference purposes.

* Nadim, Nawal El Missiri (1980) Rural health care in Egypt. IDRC. T5 15e.

Includes a description of the local customs used to "treat" infertility. The daya think that infertility is due to the presence of a cold (infection?) in some woman's lower back. They may use heated glass sucking cups to extract the excess cold, or may insert a woollen cloth soaked in "helba" (local beverage), salt, molasses, and ichthammol into her vagina for 3 consecutive days following menses. Part of a dried umbilical cord from another delivery may also be inserted into the vagina. If these measures fail, the daya may arrange for the woman to see a horrible object such as a corpse or a snake. Only women are 'treated' this way because in many traditional societies it is believed that only the woman can be infertile. It also shows how infertility is a significant problem to consider in rural health care.

WHO/MCH (1983) Report of the meeting on the prevention of infertility at the primary health care level. Document No. MCH/84.4 Eng.

4.6.

Keeping up to date with birth spacing, family planning techniques and training methods

Many national family planning associations have a regular newsletter. It is often available free of charge.

Family Planning Association Education Unit, UK Publications and courses in sex education and personal relationships.

* **Family Planning International Assistance** (?monthly)
Newsletter of the International Division of Planned Parenthood
Federation of America Inc.

* **Grapevine, UK** (monthly)

* **Information, Education, Communication, in Population (IEC)**
Newsletter, East West Communication Institute, Hawaii.

International Association of Schools of Social Work (1975)
Occasional publication: Audio visual resources for population
education and family planning, and international guide for social
work educators.

* **International Family Planning Digest** (quarterly)

* **ILO** (1982) Bibliography of ILO population and labour
policies programme publications.
Includes family welfare education materials.

* **IPPF** (regularly) Education publications list.

* **IPPF Medical Bulletin** (quarterly newsletter) Eng. Fr. Sp.
Excellent for keeping up to date on methods and trends in family
planning.

* **IPPF News** (monthly) Arabic, Eng. Fr. Sp.

* **IPPF** (regularly) Publications list.

* **People** (quarterly) Eng. Fr. Sp.
An excellent magazine for keeping up to date with ideas on birth
spacing and family planning.

* **Population Council** (regularly) Publications list.

* **Population Reports** Regular updates on all aspects of family
planning.

United Nations Educational, Scientific and Cultural Organisation
(UNESCO), Regional Population Communication Unit, Kuala Lumpur
(quarterly). Communication News.
A free newsletter on family planning projects.

World Education, Reports series. e.g. Literacy and family
planning. (1975)

* **WHO** (1982) Reference material for health auxiliaries and
their teachers. WHO Offset Pub. No.28. Eng. Fr. Includes a
concise bibliography on family planning.

5. Immunisation to prevent infectious diseases in children.



5. Immunisation to prevent infectious diseases in children.

5.1.

The need for immunisation

* Channing, L. Bete Co. Inc. (1977) Shots for tots. The importance of immunisation for your child.

A straightforward booklet written for American parents: "What is immunisation? It is a safe and effective way to prevent or fight off certain diseases. Which immunisations should my child have? The big 7 (polio, measles, rubella, diphtheria, pertussis, tetanus, and mumps)." The explanations are accompanied by cartoon drawings.

* International Children's Centre (ICC) (1979) Immunisation leaflets for mass media, university personnel, health personnel working in the field, health policy makers.

Five million children die and thousands are disabled every year from diseases which immunisation can prevent. It costs more to treat disease than to prevent it. The WHO's objective is to immunise every child in the world against preventable diseases by 1990. Information about the immunisable diseases for various categories of health workers are included in the leaflets.

Morley, D.C., Savage, F. with WHO/EPI (1983) Immunisation: clinical signs in 6 target diseases.

A set of 24 slides with explanatory text, designed for public health nurses, community nurse and medical auxiliaries. Explains the main clinical signs of the 6 target diseases. A cassette tape is also available.

TALC (1982) The cold chain: 1. How to look after your vaccine; 2. How to look after your cold chain equipment.

A set of 48 slides with explanatory text. The first five slides are of children suffering from the six target diseases in the immunisation programme.

US, Centre for Disease Control (1972) Immunisation against disease.

Diseases which are potentially or actually immunisable are reviewed. Recommendations on immunisation practices are given.

* WHO (1978) Immunise and protect your child. Colour, animated cartoon film, 5 mins.

An animated cartoon without words to motivate mothers to bring their infants to the local health centre. The message is simple: if you don't immunise your child, then he or she may not survive.

WHO (1963) The monster and you. Tuberculosis. Eng. Fr. Sp. Colour, animated cartoon film, 11 mins.

This film, aimed at the general public, deals, in an entertaining form, with the problem of tuberculosis. As it opens, an eccentric and doubting old lady appears on the screen and a dialogue commences between her and a mysterious voice emanating from a pointing finger. The voice explains to her that the monster of the title - tuberculosis - can endanger the existence

of people like herself. She is shown what the disease is, how it is spread, and what measures can be taken to put an end to it.

* WHO/EPI (no date) Recognise the disease. Eng. Fr.
A set of 30 slides and booklet to aid the diagnosis of six target diseases: Measles, tetanus, diphtheria, whooping cough, polio and TB.

* WHO/EPI (no date) Recognise the disease. Poster.
Uses the same photographs as the above slide set. The photo comes with an Eng. or Fr. text, or blank for teachers to fill in the appropriate message.

* WHO/UNICEF (1977) Protect them now. Eng. Fr. Sp. Colour film, 20 mins.
A joint WHO/UNICEF film made in Ghana, to show something of the unnecessary suffering caused to children through lack of immunisation. Their susceptibility to tuberculosis, measles, poliomyelitis, diphtheria, tetanus and whooping cough, is often heightened by malnutrition. The population is gradually accepting the idea of immunisation, particularly when it is endorsed by their own traditional healers and by village health workers.

* Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (no date) Pourquoi vacciner vos enfants? Booklet 26. Fr.

5.2. Schedule and techniques for immunisation

5.2.1. Immunisation schedule

* Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981) Community health.
An immunisation schedule for children is illustrated: p.225.

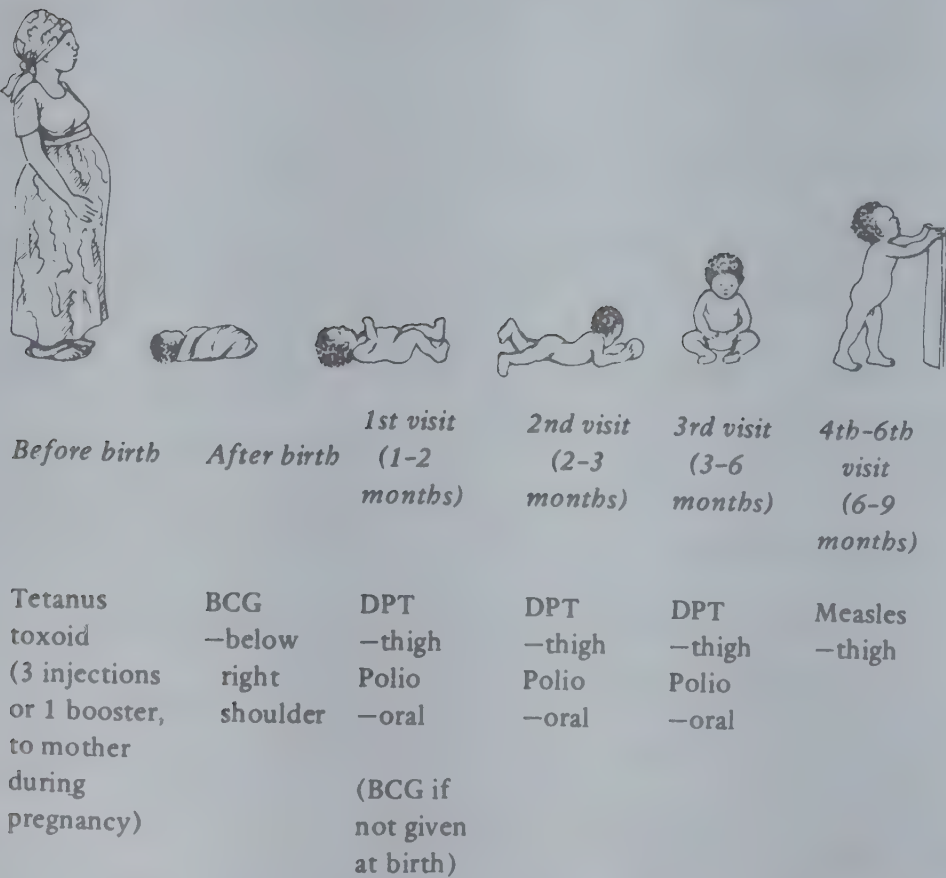


Fig. 5.1.

Fig. 9.1 Immunization schedule for children.

Vaccination sites are also illustrated: oral (polio), right arm (BCG), thigh (measles, DPT): p.226.

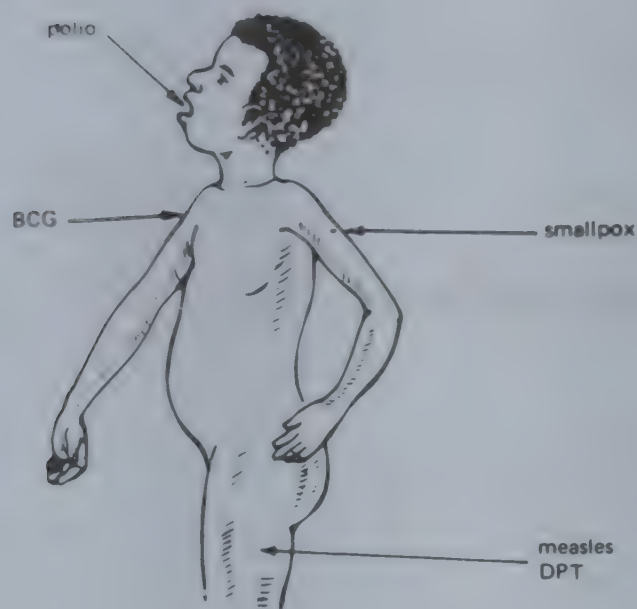


Fig. 9.2 Vaccination sites.

Fig. 5.2.

WHO/EPI Monthly child care calendar. A calendar poster, aimed at the childcare worker depicting important health interventions during the first year of a child's life.

5.2.2.

Vaccination techniques

Fillastre, C., Gateff, C. and Dutertre (1973) Vaccinations. Children in the Tropics Issue 85.

The illustrations are taken from pp.16 and 17.

INDIVIDUAL VACCINATIONS

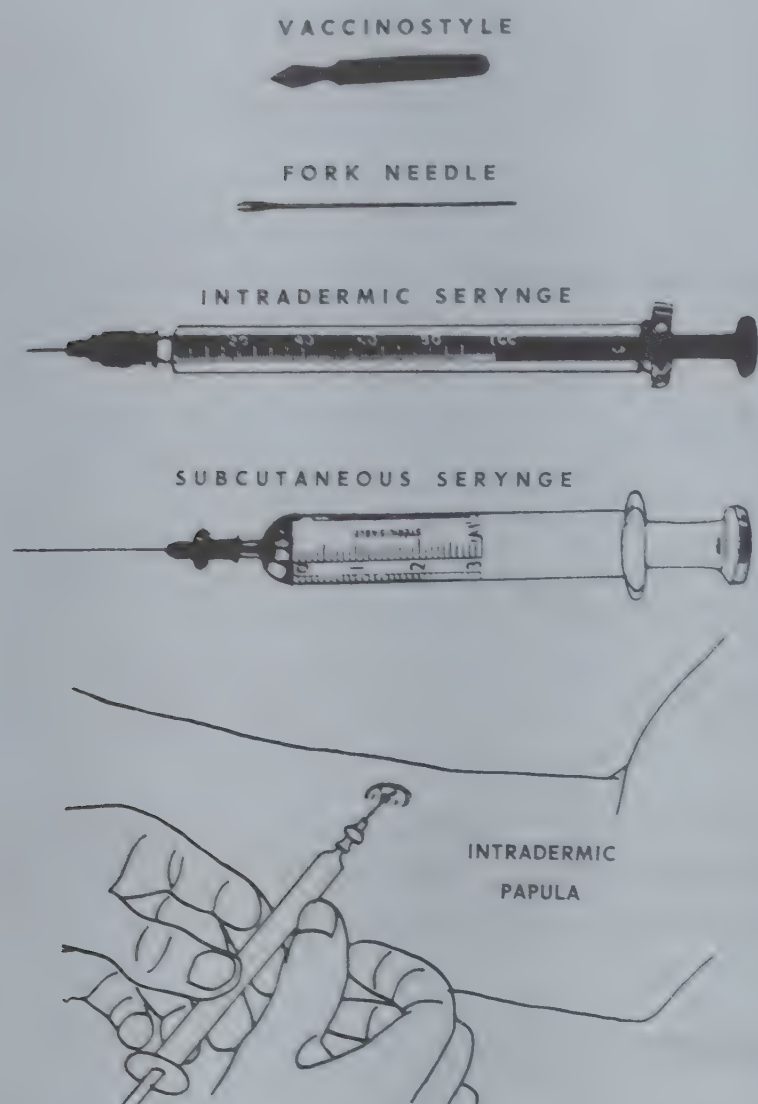


Fig. 5.3.

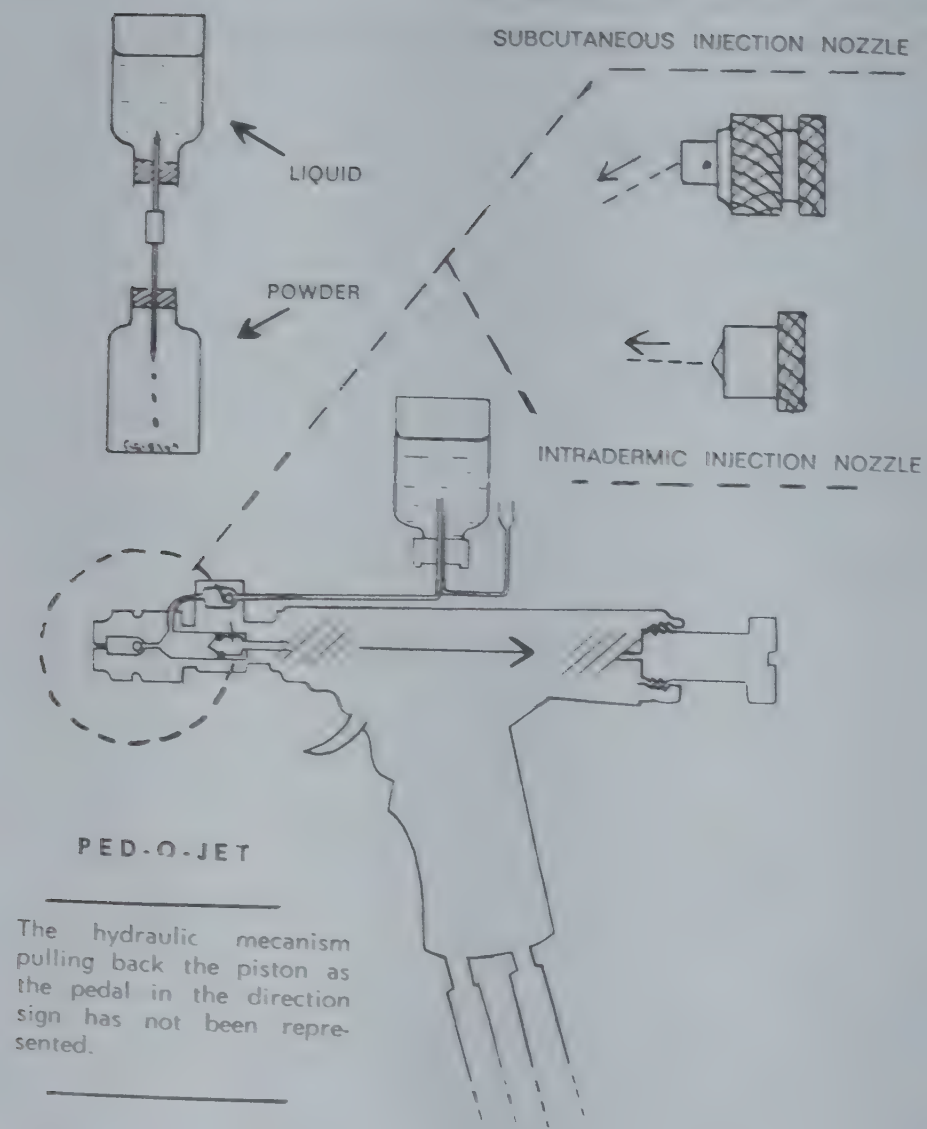


Fig. 5.4.
MASS VACCINATIONS

Huckstep, R.L. (1975) Poliomyelitis. A guide for developing countries, including appliances and rehabilitation for the disabled: p.43.

PROPHYLACTIC IMMUNIZATION



Fig. 5.5.

Laugensen, M. (1974) The intradermal jet injector.

A description of the structure, uses and advantages of the injector. The intradermal injector is faster than syringes and needles, less costly to maintain, portable and safe for non professionals to use. The workings, methods of sterilisation, and application of the injector are described in simple language.

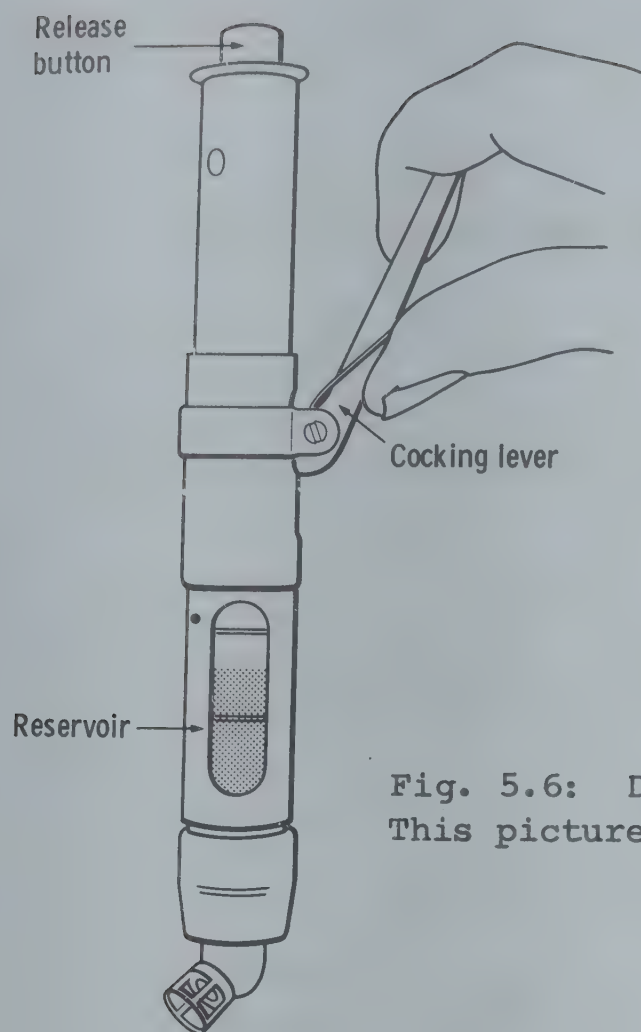


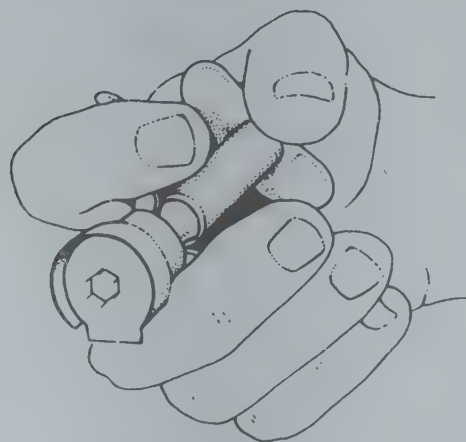
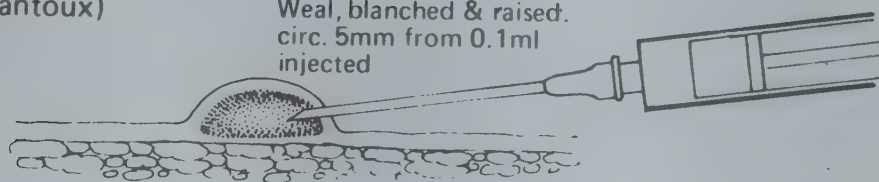
Fig. 5.6: Diagram of jet injector. Source TCHU. This picture may be reproduced.

Miller, F.J.W. (1982) Tuberculosis in children, evolution, epidemiology, treatment, prevention.
Chapter 4: BCG vaccination. The techniques of tuberculin tests are shown: p.24.

TUBERCULIN TESTS

Intradermal injection
(Mantoux)

Weal, blanched & raised.
circ. 5mm from 0.1ml
injected



HEAF APPARATUS
— Only the magnetic
model is recommended

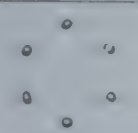

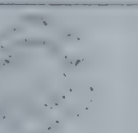

HEAF TEST READINGS				
Negative	Increasing degrees of positiveness →			
0 —	 1 +	 2 ++	 3 +++	 4 ++++
Faint marks No induration	4 or more discrete palpable papules	Papules have coalesced, normal skin inside circle	Skin obliterated inside ring of papules	Blistering present

Fig. 2.3 Tuberculin Tests; Mantoux intradermal injection, Heaf Apparatus and grades of Heaf Test results

Fig. 5.7.

WHO/EPI (1984) Immunisation in practice: a guide for health workers who give vaccines. Module 1 - Vaccines and when to give them; and Module 3 - How to give vaccines. These modules include: how to look after vaccines; the immunisation schedule; contraindications to immunisations; doses, courses and side-effects; checking a vaccine; how to prepare and give each vaccine. They are very clear, practical and well illustrated including teaching ideas and case studies for discussion.

RECOMMENDED IMMUNISATION SCHEDULE

- Mother: Tetanus toxoid: 0.5ml: 2 doses at least 4 weeks apart, before or during pregnancy. First dose at first antenatal visit - or any other visit. Second dose at least 2 weeks before expected delivery date. One dose to pregnant women previously immunised. (After 5 doses, do not give any more)
- Child: BCG: 0.05ml: Given at birth or any time after (0.1ml after 1 year of age). Best to give a second dose at school entry.
- DPT: 0.5ml: Start at 6 weeks, try and complete before 6 months, as babies under 6 months are likely to die from whooping cough. Three doses, at 6, 10 and 14 weeks, with oral polio.
- Polio: 3 drops per dose: 3 doses, 4 weeks apart with DPT. Polio vaccine can be given very early in life, even at birth, but start the normal course at 6 weeks.
- Measles: 0.5ml: 1 dose at 9 months.

5.3.1.

1 out of 3 vaccines may fail because of spoiling

* Liberia, Ministry of Health and Social Welfare/Christian Health Association (1980) EPI Handbook for health workers. "Spoiled vaccine is a waste of everyone's time and money! Spoiled vaccine does not help our children. Spoiled vaccine can spoil our name if we give it!": p.39.



Fig. 5.8.

* McBean, A.M. et al. (1976) Evaluation of a mass measles immunisation campaign in Yaounde, Cameroon. Trans. Roy. Soc. Trop. Med. Hyg. 70: pp.206-212.

Reports the results of a study showing that of 100 doses of measles vaccine, 83 were wasted: 44 doses were given to children who were already immune; 25 doses were spoilt by getting too warm; 12.6. doses of vaccine were thrown away (e.g. because a new vial was opened with only a few children who were too young (i.e. still immune from maternal antibodies) or too old (no longer at risk of getting measles). Only 17 out of 100 measles doses were beneficial.

Werner, D. and Bower, B. (1982) Helping health workers learn: p.16-3.

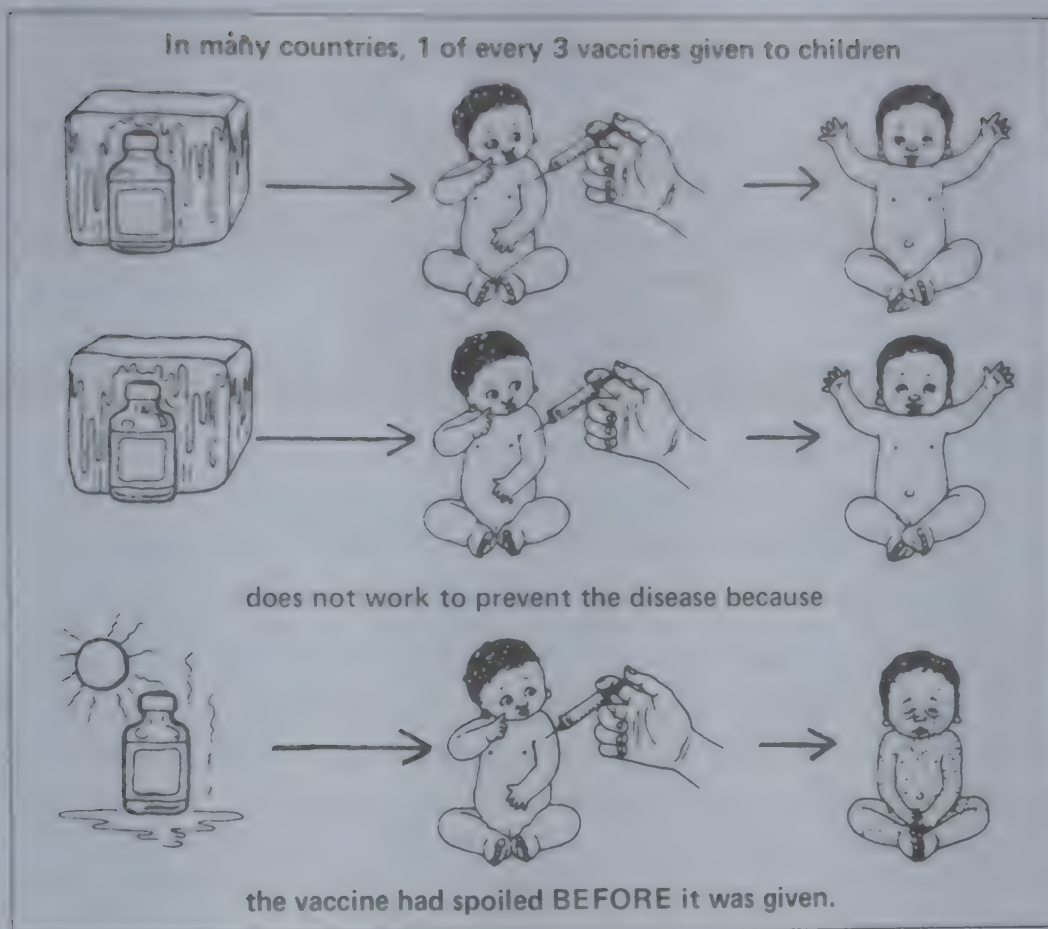


Fig. 5.9: Avoiding the problem of spoiled vaccines.

WHO/EPI (1984) Immunisation in practice: a guide for health workers who give vaccines: Module 4 - Preparing for an immunisation session, and Module 5 - How to conduct an outreach immunisation session. Deals practically with how to care for vaccines, particularly during their use in clinics. See also Module 7 - How to evaluate your own immunisation programme.

5.3.2. Cold chain teaching materials

5.3.2.1. Keeping up to date on the cold chain

* WHO/EPI (1984) An annotated cold chain bibliography. 7th revision.

5.3.2.2. Looking after your vaccine refrigerator or cold store

* Elford, J. (1980) How to look after your refrigerator. Eng. Sp. Turkish. Step-by-step instructions for the care and maintenance of kerosene, gas and electric refrigerators.

Lloyd, J.S. (1981) Monitoring vaccine storage temperatures. Offprint from WHO Chronicle 35 (2): p.51



Fig. 5.10: A liquid crystal thermometer.

The latest in a series of special thermometers designed for the vaccine cold chain is shown in the picture. By means of liquid crystal technology, the spot corresponding to the correct temperature (1°C) changes colour from dark blue to bright green. If the temperature is outside the range of the thermometer, above + 20 °C or below 0 °C, all coloured spots remain dark blue. The thermometer is made of plastic covered card (117mm x 31mm x 2mm) and is very robust. The cost is US\$ 0.85.

Monitoring the temperature of vaccines distributed through the 'cold chain' network of a developing country is one vital task of health workers and storekeepers. Failure to monitor storage temperatures risks a reduction in the potency of vaccines and could result in infants being unprotected against disease. The refrigerator may be working, but if the thermostat is set too high or too low, the vaccine is easily damaged. A recent survey in one country showed that 80% of the refrigerators containing vaccine were outside the correct temperature range and none contained a thermometer.

Not all thermometers are suitable for the vaccine cold chain in developing countries. Some are easily misread or too difficult to understand. Humid tropical climates quickly damage some thermometers and rough conditions of delivery can easily break fragile casings. Tests, sponsored by WHO on a routine basis, are being carried out to identify suitable thermometers for these conditions and to point out adaptations which may be needed. Different types of thermometer are now identified for every level in the cold chain - for use in the central, regional and district stores.

Up-to-date information on the vaccine cold chain is given in WHO/EPI (1984). An annotated cold chain bibliography. 7th revision.

TALC (1982) The cold chain: 1. How to look after your vaccine; 2. How to look after your cold chain equipment. A set of 48 slides with text. Describes how to store and handle vaccines in a refrigerator, cold box and vaccine carrier. Includes the main principles of looking after a refrigerator and other cold chain equipment. The Appendix includes the sensitivity of different vaccines and notes on the interpretation of time/tag monitors.

* WHO/EPI (1980) The cold chain game. 19pp. Eng. Fr.

Designed for middle level people planning the district and health centre cold chain. Players take on the roles of cold chain workers, storekeepers, supervisors etc.

* WHO (1978) The cold chain, or how vaccines should be handled. 16mm film optical sound track. Eng. Fr. Vaccines have to be kept cool in order not to lose their potency. This film shows the difficulties in transporting vaccines from Accra airport in Ghana to very remote villages in the hot climate of West Africa. It explains the precautions which have to be observed and the kind of mistakes that can occur. It underlines the responsibility of health workers who handle this sensitive cargo and demonstrates the proper use of 'cold boxes', or refrigerators, and how to set up the rapid, smooth-working transport system commonly known as the 'cold chain'.

* WHO/EPI (1980) A guide to estimating storage capacities for EPI vaccine. Ref.: EPI/CCIS/80.10. 2pp. Eng. Fr. A 'short-cut' method for estimating roughly the required capacity of cold rooms, bulk vaccine refrigerators, vaccine freezers, cold boxes, and ice making requirements.

WHO/EPI (1984) Immunisation in practice: a guide for health workers who give vaccines.

A set of 7 texts, or modules, together with a trainer's guide, explain what vaccinators need to know about immunisation; and they describe and illustrate what vaccinators must be able to do. A 'controlled' or simplified style of English is used. This makes the text easier to adapt and to translate into other languages. A number of suitable exercises and other teaching ideas are included. The trainer's guide includes suggestions for practical exercises, as well as answers and comments for the questions and exercises in each module. The series includes:

- | | |
|----------|--|
| Module 1 | Vaccines and when to give them. |
| Module 2 | Syringes, needles and sterilisation. |
| Module 3 | How to give vaccines. |
| Module 4 | Preparing for an immunisation session. |
| Module 5 | How to conduct an outreach immunisation session. |
| Module 6 | Health educators in an immunisation session. |
| Module 7 | How to evaluate your own immunisation programme. |
- Trainer's guide.

WHO/EPI (1983) Logistics and the cold chain for PHC.

This set of 25 modules (or booklets) aims to improve the standard of supply logistics for primary health care. Five types of supplies are described; vaccines; contraceptives; oral rehydration salts; 34 essential drugs; and chloroquine.

The 25 booklets are designed to teach the skills needed to: estimate the demand for supplies; store the supplies properly; and distribute the supplies properly. They are aimed at anyone who handles supplies for primary health care, but there is a special emphasis on the problems found in developing countries.

The booklets are:

1. How to estimate requirements for the first time.
2. How to estimate chloroquine requirements for the first time.
3. How to estimate ORS packet requirements for the first time.
4. How to estimate vaccine requirements for the first time.

5. How to estimate MCH supply requirements for the first time.
6. How to estimate essential drug requirements for the first time.
7. How to estimate requirements for an existing store.
8. How to store supplies.
9. How to distribute supplies.
10. How to keep records, control quantity of stocks and reorder supplies
11. How to control quality of stocks.
12. How to run a discussion group.
13. Logistics game.
14. How to improve communication.
15. How often do you need to hold an immunisation session.
16. How to look after a compression refrigerator.
17. How to look after a kerosene refrigerator.
18. How to look after a gas refrigerator.
19. How to keep stocks of spare parts.
20. How to look after a cold store.
21. How to supervise and train.
22. How to retrain vaccinators.
23. Answer sheets.
24. Summary sheets.
25. Evaluation questionnaire.

* WHO/EPI (no date) Look after your vaccines every day; Look after your vaccines every week; Look after your vaccines every month. Posters. Eng. Fr. Blank for overprinting in any other language.

A set of three comic strip style posters to remind field level health workers of the steps to be taken every day, week and month to ensure that vaccine is available in the proper qualities and properly protected.

* WHO/EPI (no date) Looking after your cold chain equipment. A set of 20 colour slides. Text: 10pp. Eng. Fr. Illustrates the daily maintenance required to keep cold chain equipment running effectively. Practical suggestions are made on how to get the best performance out of refrigerators used for storing vaccines.

* WHO/EPI (no date) Looking after your vaccine. A set of 20 colour slides. Text: 8pp. Eng. Fr. A slide set with an accompanying text, to train field level workers in proper vaccine handling. The subjects presented are: the importance of keeping vaccine cold, proper refrigerator loading, use of cold boxes and vaccine carriers. Practical suggestions are given on procedures for conserving vaccines in an emergency.

WHO/EPI (no date) Love your refrigerator. Poster.

* WHO/EPI (1981) Product information sheets. Ref.: SUPDIR 55 AMT 3. 103pp. Eng. Fr. Sp. "An essential reference for people buying equipment for the vaccine cold chain. This latest revision contains detailed specifications for 8 types of cold room, 2 refrigerated vehicles, 21 types of refrigerator and freezer, 30 types of cold box and

vaccine packaging, 4 types of cold pack, 11 types of thermometer and other miscellaneous items such as an alarm system, a voltage stabiliser and a refrigerator maintenance toolkit." This document is also distributed by UNICEF.

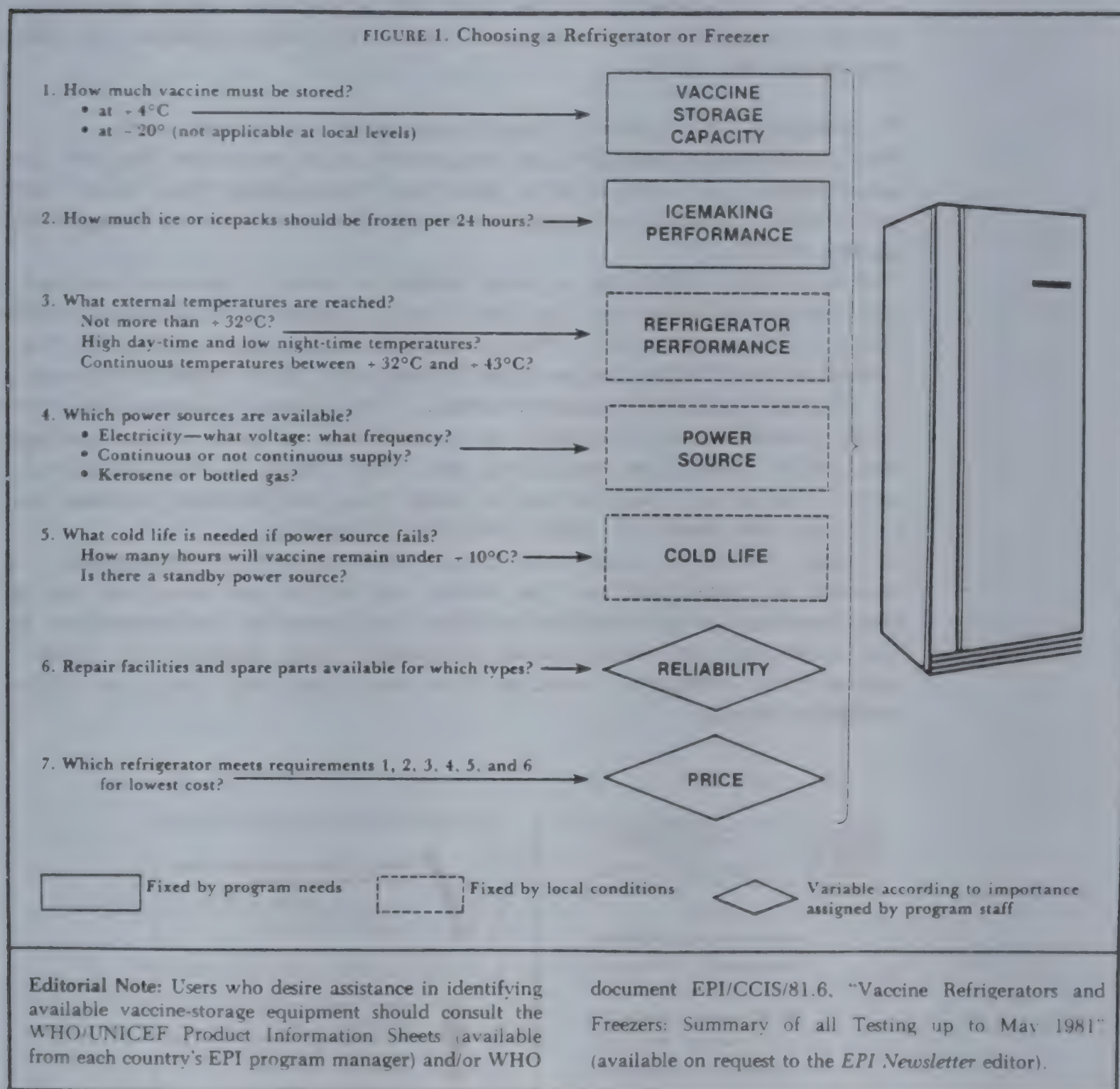


Fig. 5.11. EPI Newsletter (1982) IV (2): p.5.

* WHO/EPI (1981) Solar refrigerators for vaccine storage and icemaking. Ref.: EPI/CCIS/81.5. 19pp. Eng. Fr. This paper describes the 'state of the art' of solar refrigerators for the vaccine cold chain. Fourteen different projects from 11 countries are described in terms of their vaccine capabilities, ability to make ice and details of their progress to date. Also, the five different systems of solar refrigeration are described, with some estimates of when each system will be available and its reliability, ease of installation and cost.

* WHO/EPI (no date) STOP. Do you need to open it? Eng. Fr. Sp. Arabic. Chinese.
A sticker for refrigerator doors.

* WHO/EPI (no date) This refrigerator protects lives. Poster Ref.: WHO 79188. Eng. Fr. Sp. Arabic.
A poster intended for the door of a vaccine refrigerator. It gives instructions on how to load the refrigerator to get the best performance.

* WHO/EPI (no date) Time/temperature tag monitors.
The cold chain monitor is attached to a vaccine box at the central warehouse. It stays with the box throughout the cold chain, recording cumulative exposures of the vaccine to temperatures above +10 °C.
The monitor contains a blue chemical which spreads across the calibrated window as the vaccine is exposed to temperatures above the +10 °C threshold. The chemical stops spreading if the temperature falls below the threshold, and advances more quickly at higher ambient temperatures. Its spread cannot be reversed, thus preserving information needed for a cold chain manager's analysis. Vaccine handling has been good if the chemical does not move, while any migration across the calibrated window indicates the vaccine has not been handled properly.
At each point in the cold chain the amount of exposure, if any, should be recorded on the chart to which the monitor is attached. The monitor's calibrated window can provide information to locate failures in the cold chain and alert the manager to take corrective steps to ensure that vaccines are kept at correct temperatures.

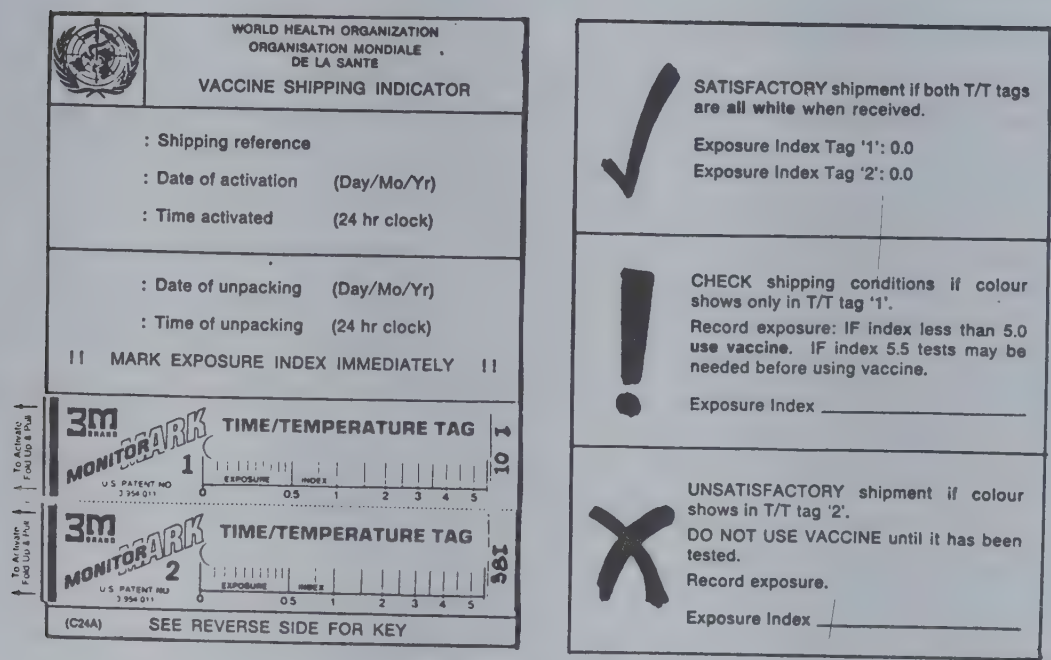


Fig: 5.12: Time/temperature tag monitors cumulative exposures of vaccine to temperatures above +10 °C.

* WHO/EPI (1980) Training the trainers in cold chain operations. WHO Chronicle 34 (57): pp.182-185. Eng. Fr.
A general and comprehensive article describing the objectives and content of a logistics and cold chain workshop run by WHO/EPI.

* WHO/EPI (1981) User's handbook for vaccine cold stores.
47pp. Eng. Fr.

This draft booklet is the first of eight produced in 1981 on cold chain equipment maintenance. The first 8 pages give advice on daily, weekly and monthly cold room maintenance. The following 35 pages describe the 27 most common faults in a typical vaccine cold store. Diagnosis and repair procedures are described in a way understandable to a practically-minded storekeeper. The final two pages list the tools and spare parts that are needed in a typical cold room.

Other titles available include:

User's handbook for compression refrigerators.

User's handbook for gas and electric operated refrigerators.

User's handbook for kerosene and electric operated absorption refrigerators.

* WHO/EPI (no date) Vaccine. RUSH.

Fr. Sp. German. Arabic.

A sticker for vaccine packages, giving a warning about proper handling. It is accepted by IATA for air travel.

5.3.2.3. Cold boxes and vaccine transport care

Battersby, A. and Jansdaal, P. (no date) How to choose and make a cold box.

A clear practical manual which allows decision makers to choose the right kind of cold box to buy or to make.

See also WHO/EPI (no date) Vaccine. RUSH sticker.

and WHO/EPI (no date) STOP. Do you need to open it? sticker in Section 5.3.2.2.

5.3.3. Vaccine vial use and sterilisation

Lovedee, I.M., Clarke, W.D., Mangay Maglaccas, A. and Shah, K.P. (1982) A TBA trainer's kit.

How to sterilise syringes by boiling when you have no clock. See Section 1.2.1.

* WHO/EPI (1984) Immunisation in practice: A guide for health workers who give vaccines. Module 2 - Syringes, needles and sterilisation.

A practical well illustrated guide - includes how to sharpen a needle.

WHO/EPI (no date) Posters: (1) Vaccine vials: use it today. Finish or destroy open vials the same day. (2) Only use sharp straight needles (no barbed needles). (3) Rinse, clean, then sterilise all syringes and needles after each session. Boil for at least 20 minutes.

5.4. Packages for teaching planning, organisation and evaluation of immunisation programmes

5.4.1. For district level supervisors

* **Kenya, Ministry of Health** (1980) Health workers' training pack on immunisation: Vol.I. Course outline and trainer's guide. (11pp.); Vol. II Workers' manual. (120pp.); Vol.III Exercises. (23pp.)

A very useful pack, because:

- 1) Each manual has a precise function and is directed at a defined person.
- 2) The exercises for the trainees are based on their using what knowledge and experience they already have, and only when this and common sense fail are they directed into the information manual.
- 3) Trainees are required to practise the skills they have learnt. Case studies are used.
- 4) Brief and effective directions are provided for trainers so they will avoid merely giving a poor lecture.

* **Liberia, Ministry of Health and Social Welfare/Christian Health Association** (1980) EPI handbook for health workers. Excellent. A well illustrated and often amusing local production. A good example for other countries.

* **WHO/EPI** (1984) Immunisation in practice: a guide for health workers who give vaccines.

A set of 7 texts or modules together with a trainer's guide to make up a training manual for peripheral health workers who will give vaccines. The texts explain what vaccinators should know and illustrate what they must be able to do.

The texts include:

- | | |
|----------|--|
| Module 1 | Vaccines and when to give them. |
| Module 2 | Syringes, needles and sterilisation. |
| Module 3 | How to give vaccines. |
| Module 4 | Preparing for an immunisation session. |
| Module 5 | How to conduct an outreach immunisation programme. |
| Module 6 | Health education in an immunisation programme. |
| Module 7 | How to evaluate your own immunisation programme. |

There is also a trainer's guide which includes practical exercises as well as answers and comments for the questions and exercises in each module. Clear, simple, well illustrated.

WHO/EPI (1983) Peripheral health worker training materials. EPI/PHW/83/TM. 1-6 Rev.2.

A series of six modules comprising:

1. Training in recording child's growth. Eng. Fr.
2. A health worker's immunisation day. Eng.
3. Health education guidelines for immunisation sessions. Eng.
4. Preparation and administration of EPI vaccines. Eng.
5. Cleaning and sterilising instruments. Eng.
6. Monthly child care calendar: user's guide. Eng.

* **WHO/EPI** See also cold chain training materials Section 5.3.2.

5.4.2.

For mothers

* WHO/EPI (1984) Immunisation in practice: a guide for health workers who give vaccines: Module 6 - Health education in an immunisation programme.

* WHO/EPI Monthly child care calendar poster showing timing of immunisations.

5.5.

Keeping up-to-date with new ideas about immunisation

* EPI Newsletter of the Americas (monthly) Expanded Program on Immunization, Pan American Health Organization, 525 Twenty-third Street, N.W., Washington D.C. 20037, USA.

US, Centre for Disease Control (three times a year) Immunisation Abstracts and Bibliography. Department of Health, Education and Welfare; Centre for Disease Control, Atlanta, Georgia 30333, USA.

An annotated bibliography, closely typeset but useful for updating information at the country (and possibly district) level.

6. Prevention of MCH disease through promotion of environmental health and hygiene.



6. Prevention of MCH disease through promotion of environmental health and hygiene.

6.1. Water protection, collection and storage

6.1.1. Safe and effective water collection and distribution

6.1.1.1. Evidence of the influence of clean water supply on reduction of disease

Feachem, R. (organiser) (1983) International workshop on measuring the health impact of water and sanitation programmes. Cox's Bazaar, Bangladesh, 21-25 November 1983.

Useful papers presented at this workshop include 1) Black, R.E. Diarrhoeal disease and morbidity and mortality in infants and children: 31pp. + tables. 2) Esrey, S.A. and Habicht, J.P. Nutritional anthropometric indicators for evaluating water and sanitation projects.

* **McJunkin, F.E.** (1982) Water and human health. 34pp. See especially Section 9: Health impacts of community water supplies: pp.87-100, and Bibliography: pp.101-5.

USAID (1980) Water supply and diarrhoea; Guatemala revisited, by David Dworkin and Judith Dworkin. AID Evaluation Special Study No.2.

White, A. et al. (no date) Evaluacion del impcato de on servicio de Aguo tratada en Zona rural: estodios de Salud y socio-economico en Alto de Ros Idolos, Huila. Sp. Mimeo.

6.1.1.2. Finding and protecting sources of water

N.B. This section includes both actions that villagers can take themselves with a little help, and large programmes run by agencies.

* **Billington, R. (ed)** (1978) Finding sources of water. In: Health has many faces. Has sections on pumps and pipes for moving water; storing water; making water pure; improving existing water supplies (protecting springs).

* **Cairncross, S. and Feachem, R.** (1978) Small water supply. A well illustrated and well written booklet, aimed at improving water supplies for small communities ranging in size from an individual household to a village of up to 1000 people. The methods of calculating the amount of water to be used are shown. Recommends using rain water from clean roofs, ground water if deeper than 30 metres, but ideally, protected spring water. In the absence of naturally pure water, the alternative is to use tube wells, dug wells, or boreholes. The advantages and limitations of each source of water are discussed. Deals with

methods of raising and protecting wells, and then water treatment (storage and sedimentation, filtration, disinfection, aeration, use of salt and fluorine), although some of the methods may not be practical for small communities. There are also sections on distribution by pipes - including the use of bamboo. Since bamboo pipes do not last for more than five years, their durability can be increased by using green bamboos and soaking them for several hours in a solution of borax and boric acid. If chlorine is used to disinfect the water, it will be absorbed by the bamboo. The last chapter deals with the purification of water at home using a *lavas* filter (a bag), a sand filter, a ceramic and paper filter, a chemical disinfectant, or boiling. An appendix on the 'bacterial analysis of drinking water' is also included.

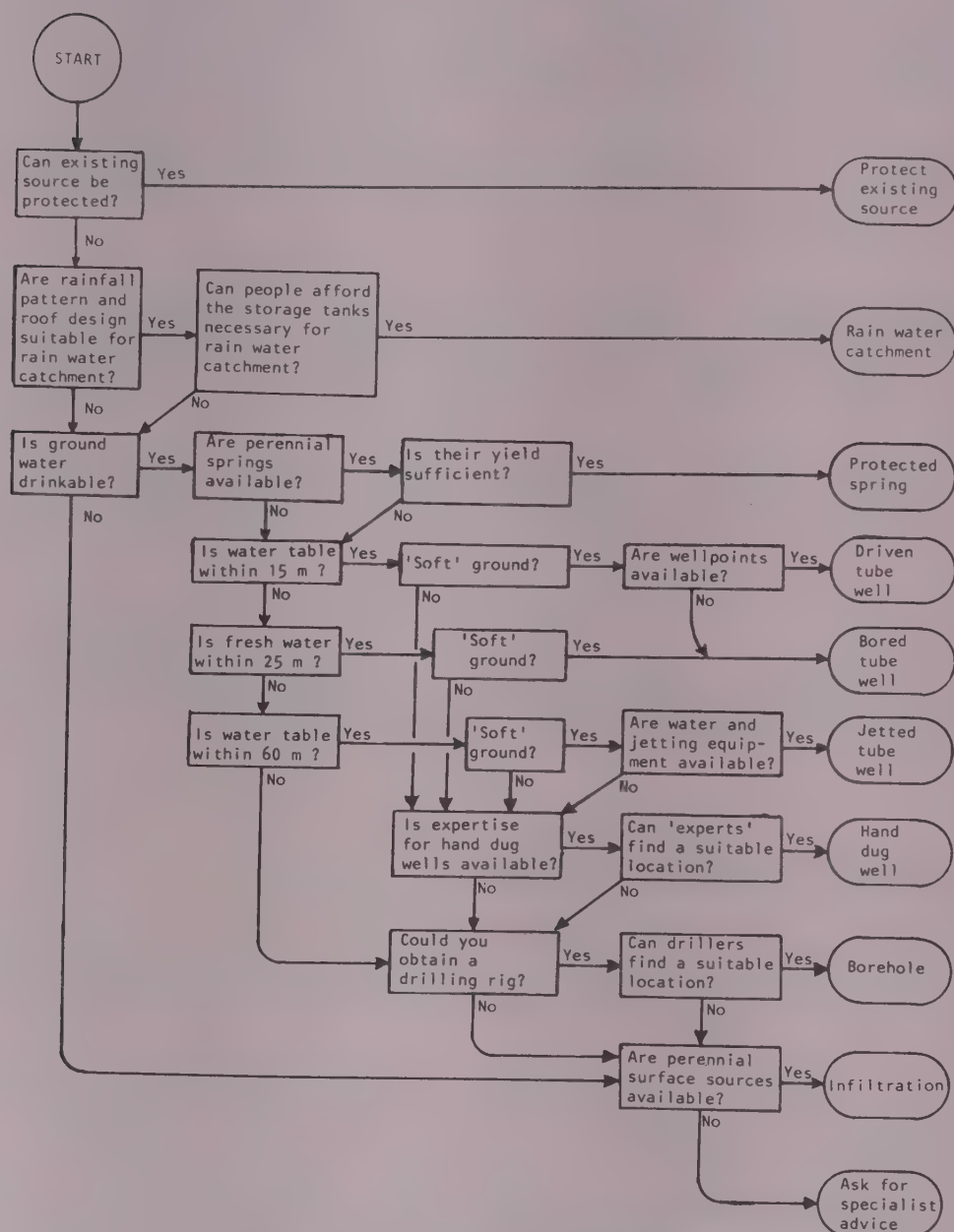


Fig. 2. Choosing a source of water. Follow the arrow corresponding to your answer to the question in each box.

Fig. 6.1.

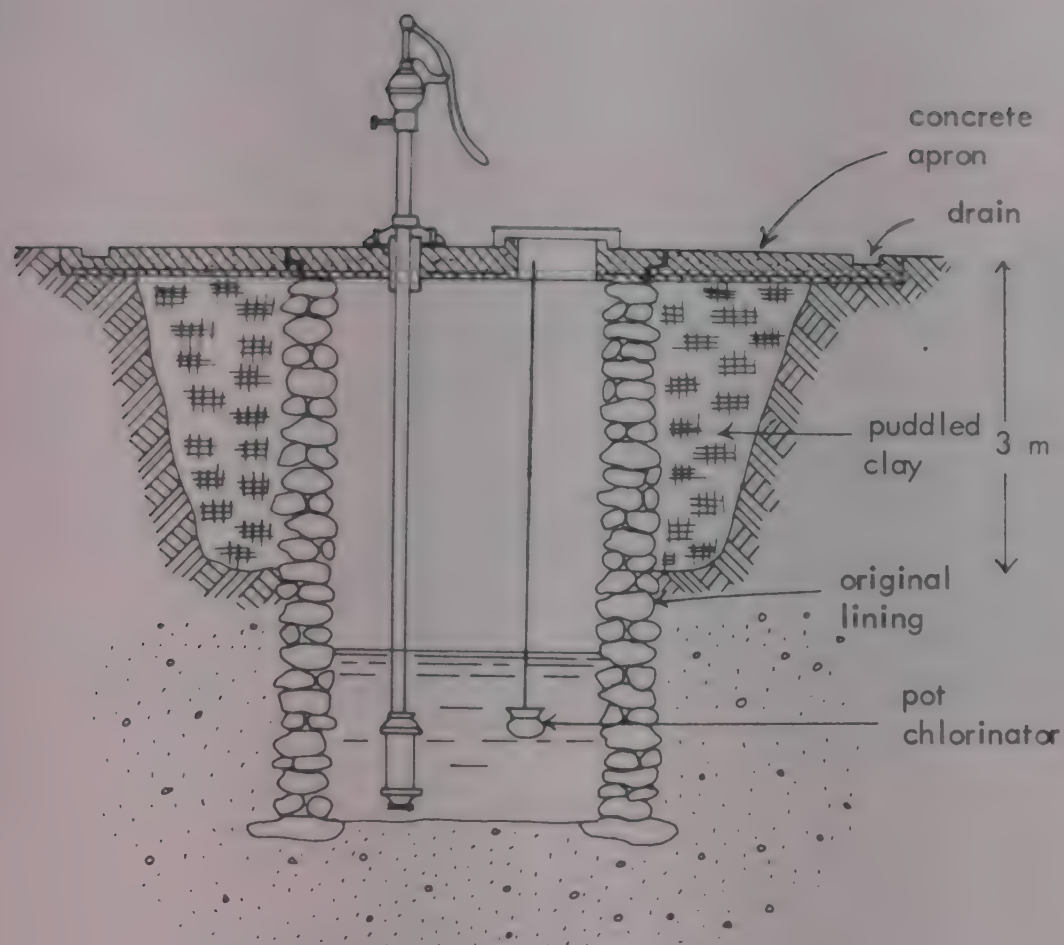


Fig. 12. Improving an existing well. (After Wagner and Lanoix).

Fig. 6.2.

Columbia University Press (1961) Water. Animated cartoon film. 15 mins. colour. Eng. Fr.

National and international action on many fronts will be required to meet the world water crisis. The film deals briefly with water resource development and raises many questions. Its purpose is to arouse public interest and to stimulate action.

De Laet, C., Gimpel, J., Elton, J., and Baghdadi, A. (1979) Models for rural development.

This is a catalogue of models of various water technologies, mostly mediaeval, but which are 'appropriate' resources for communities who cannot afford high technology today. It includes: water wheels; electric generators; floating mills; windmills; the Archimedean Screw for raising water from rivers; the 'Shaduf' or Swape (a leverage rod made of a long piece of wood 4-6 metres with counterweight, used to raise water in a bucket); methods of protecting a dug well from pollution (by redirection and fencing); and others. All of these models are photographed in the catalogue (black and white) with a short description of how they are constructed and their applications. Examples from field work where these technologies are still in use are cited.



Fig. 6.3: Protection of wells.

DHV Consulting Engineers (1978) Shallow wells. 175pp. 146 colour pictures.

This is a full colour illustrated book from fieldwork in one region (Shinyanga) of Tanzania. The experience gained from the fieldwork is summarised under the headlines: Setting up a well construction project; Selection of well sites; Well construction; Hand pumps; Maintenance of wells and pumps; Logistics and administration; and Costs.

* FAO (?1980) Rural home techniques: Labour saving ideas Vol.6. Series 3. Eng. Fr. Sp.

A useful series of four page leaflets which includes the following topics:

- Improved water hole - No.13;
- Surface water catchment - No.14;
- Improved spring - No.15;
- Reservoir for a spring - No.16.

Each leaflet gives well-illustrated straightforward instructions for construction or improvement of water holes and reservoirs.

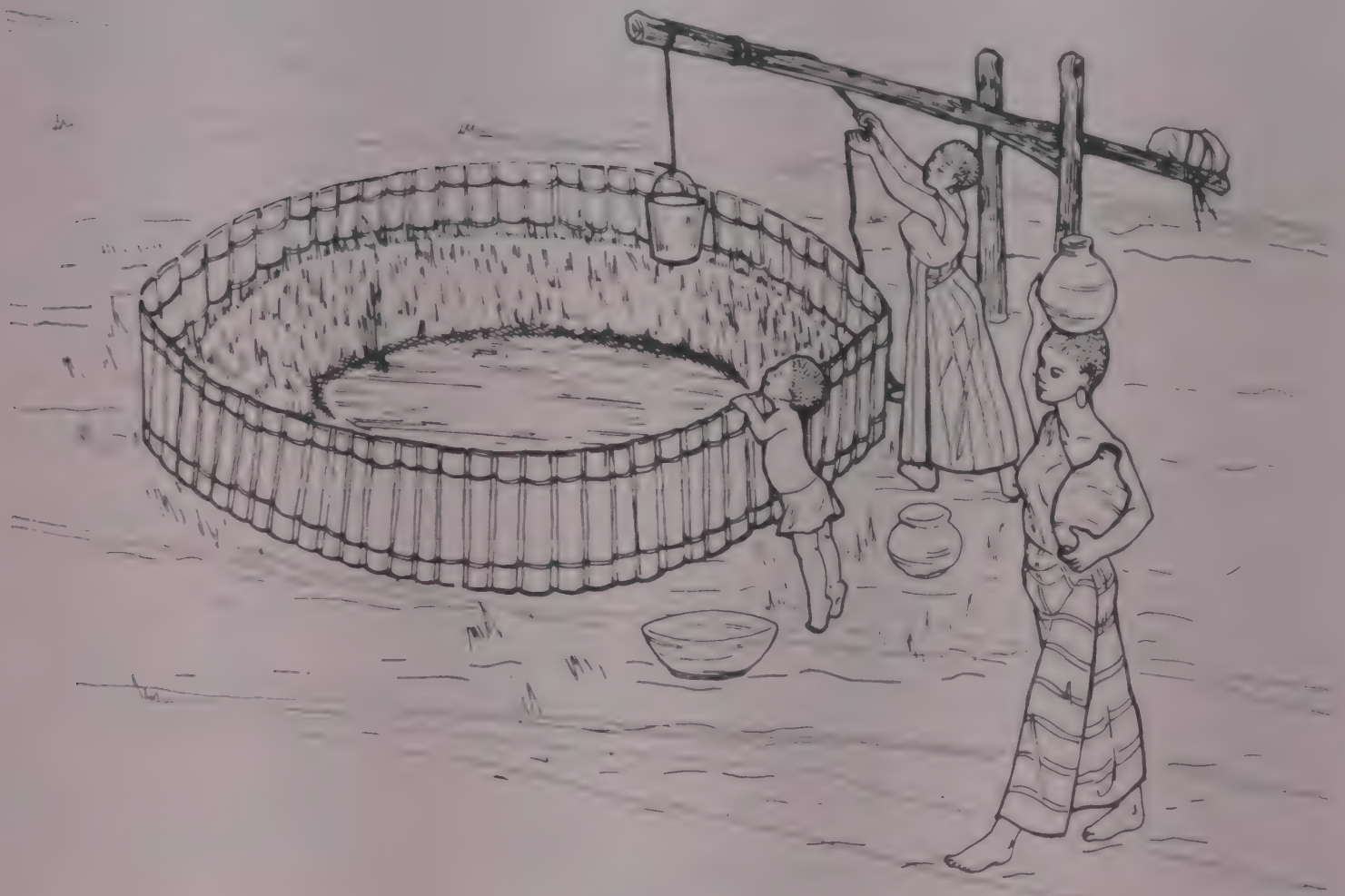


Fig. 6.4: Improved water hole.

India, Ministry of Information and Broadcasting (1966) How to get safe drinking water.

"If you use water from a well:

Get the well cleaned and disinfected. If possible, get the well covered and install a pump for drawing the water.

If the well is not covered, see that no dirt or rubbish is thrown into it.

See that there is no pit latrine or cess pit within 25 feet of the well.

Drain away the water spilt near the well and do not allow surface water to flow into it.

Keep the buckets on a clean surface. Do not place buckets used for drawing water from the well on ground which is walked on.

Do not wash clothes or bathe near the well; otherwise, impure water will get into it.

Keep clean the vessels and rope you use to take water out of the well."

* IRC (1981) Small community water supplies. Technical Paper Series 18. 378pp. 244 figures, 24 tables.

A handbook/source document on the technology of small community water supply systems. The subjects covered include: planning and management of small water systems; drinking water (quantity and quality); water sources (rainwater harvesting, spring water

tapping, groundwater withdrawal, surface water intake, artificial recharging, pumping); water treatment (general) - aeration of water, coagulation and flocculation, sedimentation, slow sand filtration, rapid filtration, disinfection; water transmission; and water distribution. Annexes provide information on: sanitary surveys; well drilling methods; experimental studies for water treatment plant design; chemicals used in water treatment; and conversion of measurement units.

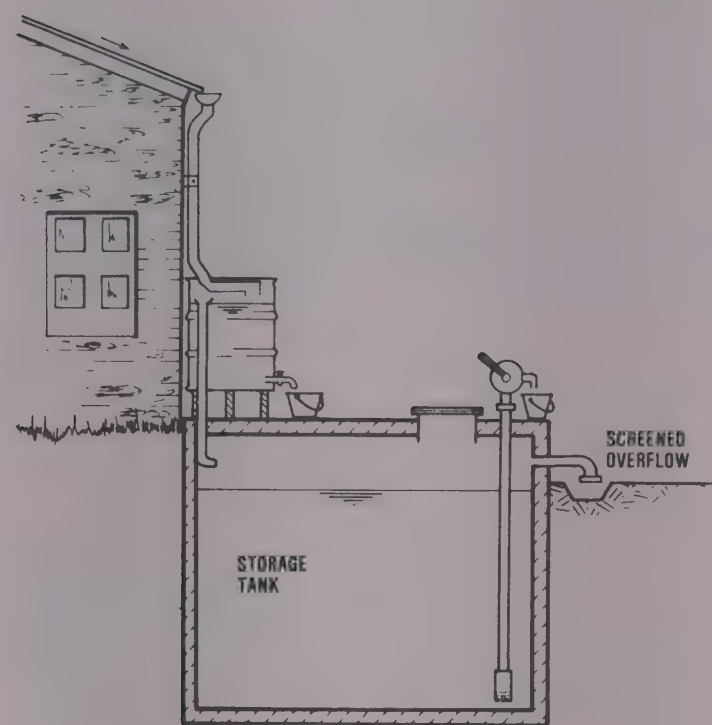


Fig. 6.5 - 6.11: Water collection, storage, sources.

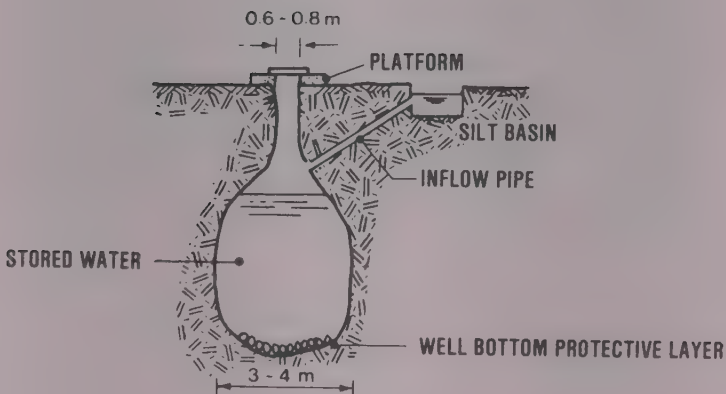


Fig. 6.6: Underground rainwater storage well (as used in China):

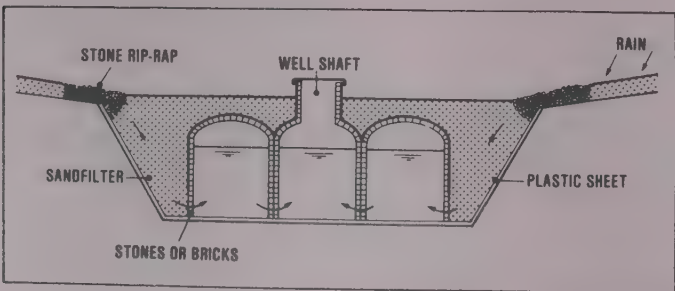


Fig. 6.7: Cistern built of polythene tubes: p.67.

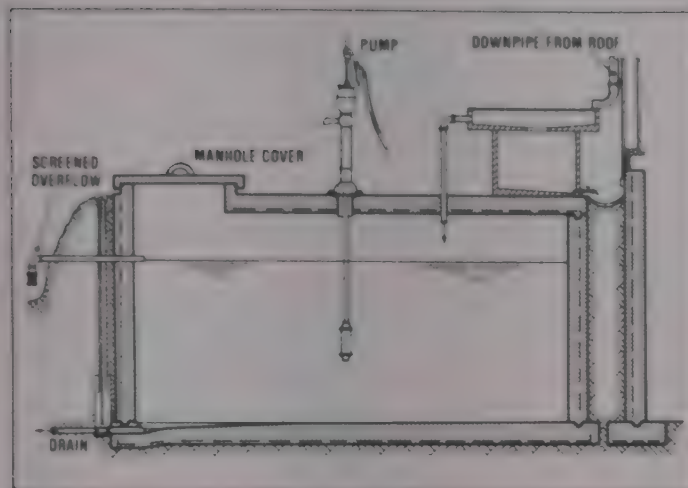


Fig. 6.8: Rainwater storage arrangement: p.67.

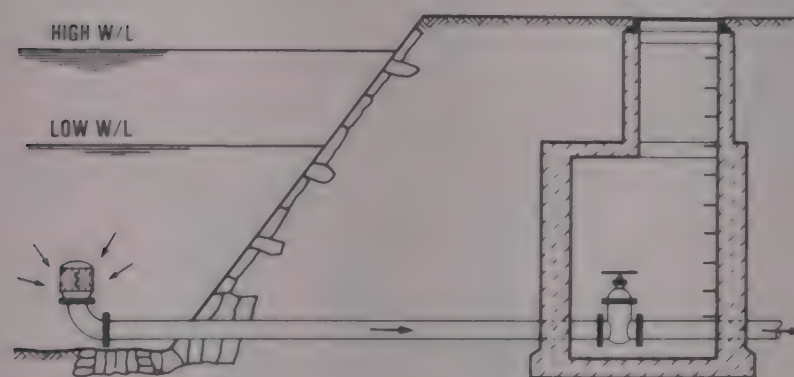


Fig. 6.9: Unprotected river intake: p.137.

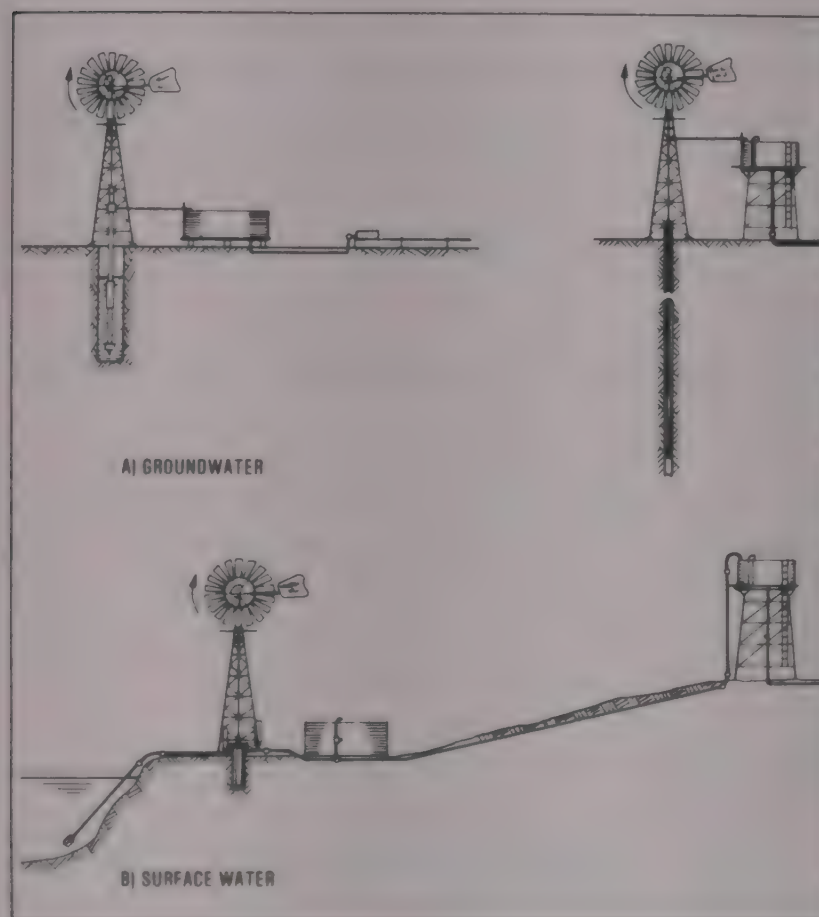


Fig. 6.10: Windmill-pumped water supply systems: p.166.

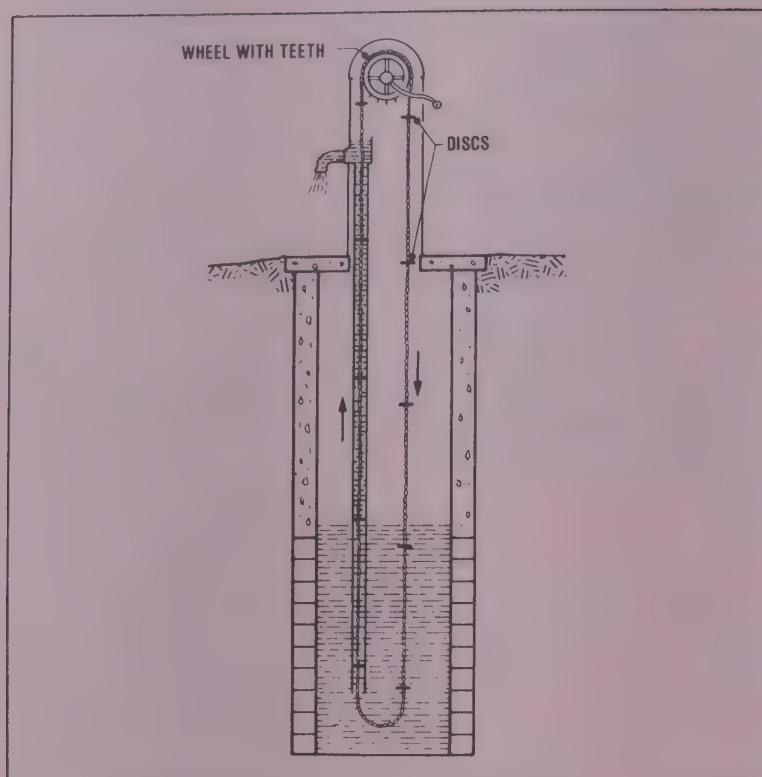


Fig. 6.11: Chain pump: p.175.

League of Red Cross Societies (1982) Healthy living. Course 1 (Part of health education programme). Guide for instructors. Eng. Fr. Sp.

Includes a useful section on protection of springs (by fencing and using a short length of piping or bamboo sunk into the ground to prevent water passing over the surface soil). It also covers collecting rainwater; improving wells (e.g. build up the ground, use one bucket on a rope, a cover on the well, a turning handle on the top, etc); and describes various filters: pp.23-27.

* **McJunkin, E.F.** (1977) Handpumps for use in developing countries. Eng. Fr. Sp.

Mara, D. (1982) Appropriate technology for water supply and sanitation.

A short paper describing in non-technical language the various low-cost sanitation technologies that are currently available for low income communities in developing countries. Also sets out a general methodology for local sanitation programme planning.

* **Peace Corps** (?1981) Wells construction. Hand dug and hand drilled. 284pp.

A useful 'how-to manual' of principles and techniques.

* **Scotney, N.** (1976) Health education; a manual for medical assistants and other rural health workers.

Chapter 3: Changing health habits. Provides an example of preventing buckets contaminating a well.

* **Thailand, Ministry of Health** (1981) Community health volunteers' nutrition and health work manuals. Rainwater collection is illustrated.

"Rain water should be collected from a clean roof and drained into a clean receptacle with a tight lid so that the water can be used throughout the year. The receptacle might be, for example, an earthenware jug, a metal or concrete tank."



Fig. 6.12.

* Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981) Community health.

Chapter 8: The environment and health. "By environment is meant the immediate and direct milieu surrounding the community or the individual. It is composed of physical (water, climate), biological (plants, animals), and social (family, village, culture) components." With regard to water, the sources (rain, surface), the quantity (little, abundant) and the quality (safe, contaminated) are the key topics covered by this chapter.

World Bank (1980) Water supply and waste disposal. Booklet. 46pp.

Includes chapters on: the size of the problem, alternative technologies, people and organisations, economics and finance.

* WHO (1981) Drinking water and sanitation 1981-1900. A way to health.

Discusses the constraints on delivering safe water supply.

Suggests some ways that could help to overcome them (e.g. community concern, involvement) nationally and internationally.

* World Neighbors International (no date) Drink pure water.

A set of 34 slides on how to take care of one's own source of water - the well, ponds, etc. Protection from animals, urine and faeces. The danger of drinking contaminated water is explained in simple English with the help of photographs.

World Neighbors International (no date) Water and diarrhoea.

A simple and straightforward set of 39 slides which answers the questions: Is all water good to drink?; What makes water impure,

not suitable for drinking?; Can we get diarrhoea from drinks of impure water?; Can typhoid fever be transmitted by water?; Why do some children have swollen bellies? etc.

6.1.1.3

Community aspects of water supply

BRALUP (Bureau of Resource Assessment and Land Use Planning, University of Dar es Salaam) and IRC (1982) Village water supply and community participation in Tanzania, Report of a National Workshop held in Dar es Salaam, July 1981.

Elmendorf, M. and Buckles, P. (1978) Socio-cultural aspects of water supply and excreta disposal, for World Bank Research Project on Appropriate Technology for Water Supply and Waste Disposal in Developing Countries. Public Utilities Report No. RES 15.

Van-Wijk-Sijbesma, C. (1981) Participation and education in community water supply and sanitation programmes: A literature review. 2nd revised edition.

Van-Wijk-Sijbesma, C. (1979) Participation and education in community water supply and sanitation programmes: A selected and annotated bibliography.

White, A. (1981) Community participation in water and sanitation, concepts, strategies and methods.

Whyte, A. (ed) (1983) The Colombian field manuals and training guides for the promotion of community participation in water and sanitation schemes.

Uses Colombian materials from the mid 1970s.

Whyte, A. (1983) Guidelines for planning community participation in water supply and sanitation projects. WHO unpublished document No. ETS/83.8.

6.1.1.4

Keeping up to date with water newsletters

* **Decade Watch** (quarterly) UNDP Division of Information, One UN Plaza, New York, NY 10017, USA.
Non technical information on clean water and sanitation.

* **Intermediate Technology Publications Ltd.** (quarterly) Waterlines. 9 King Street, Covent Garden, London WC2E 8HN, UK.
Eng., Sp edition planned.
Focuses on appropriate technology for water supplies and sanitation, aimed at communities, field workers, volunteers and project organisers.

* **International Drinking Water Supply and Sanitation Decade Newsletter** (? monthly) UNDP Division of Information, One UN Plaza, New York, NY 10017, USA.
Includes case histories and reviews of topics, e.g. guinea worm prevention.

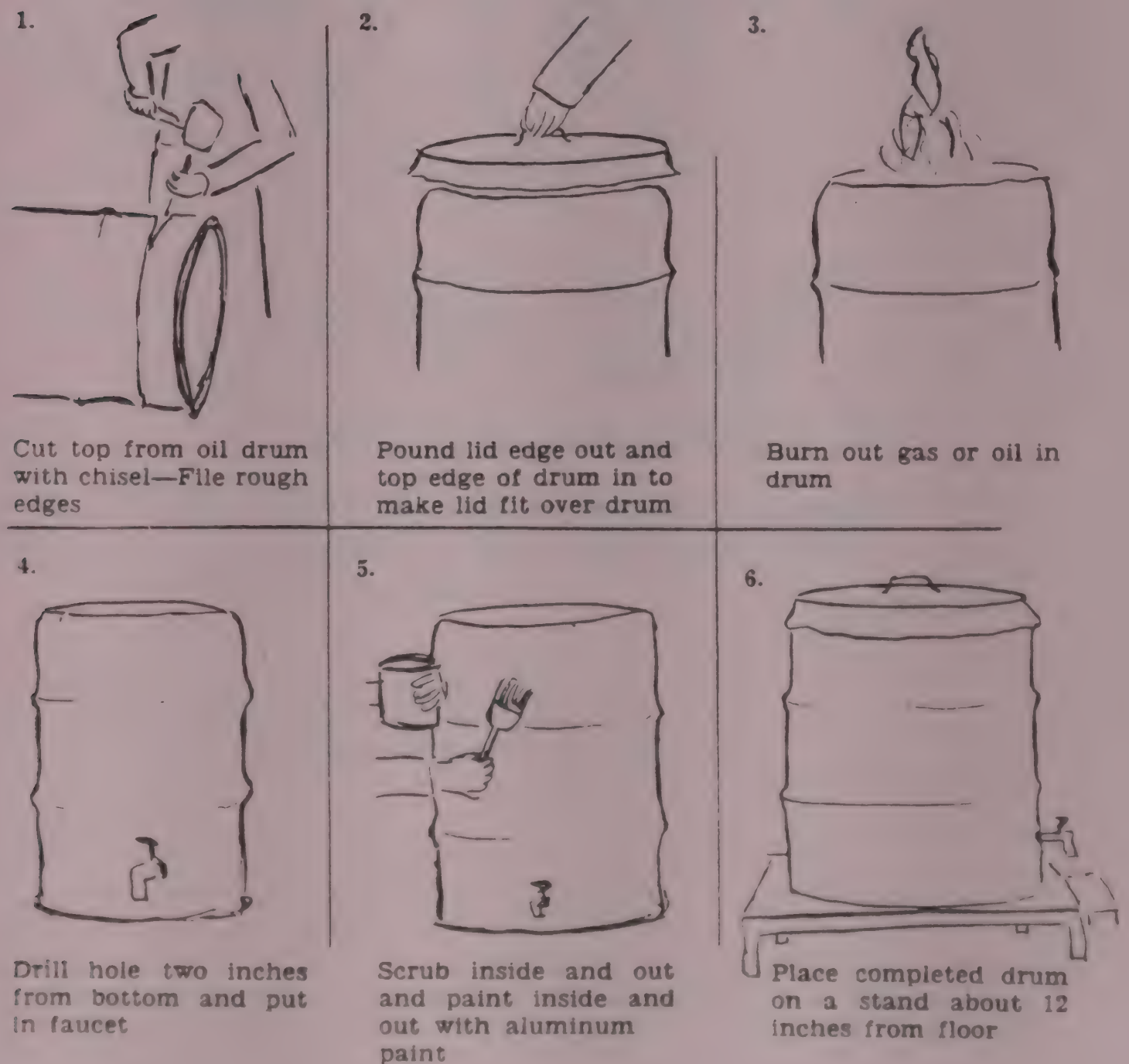
- * International Reference Centre for Community Water Supply. (IRC) (Monthly) IRC Newsletter. PO Box 5500, 2280 HM Rijswijk, The Netherlands. Eng. Fr. Provides regular update of new technologies and publications.
- * Waterfront. UNICEF. New York, NY 10017, USA.

6.1.2. Safe and effective water storage

See also Section 1.1

- * Alaska, Dept. of Health (1965) Health and first aid guide for home and village. Illustrates how to store water in a recycled oil drum.

STORE WATER IN A CLEAN WAY



Keep cover on drum except when filling

Fig. 6.13.

FAO (? 1980) Rural home techniques: Labour saving ideas, Vol. 6. Series 3. Eng. Fr. Sp.
Topic No. 12: Bamboo piping .

Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981) Community health.
Illustrates the 3 pot system of water storage: p 192.

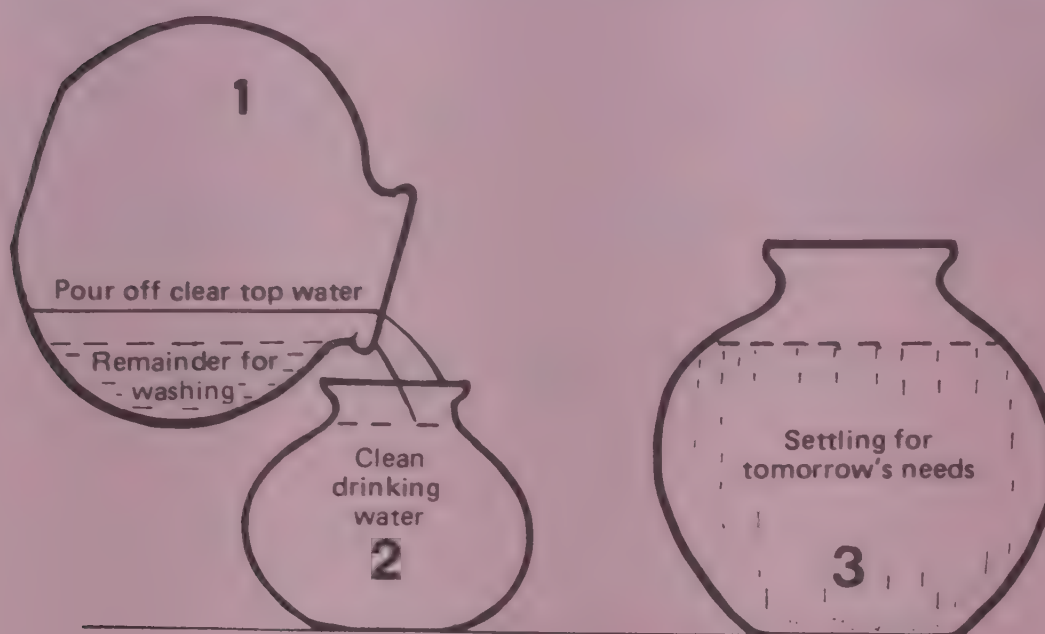


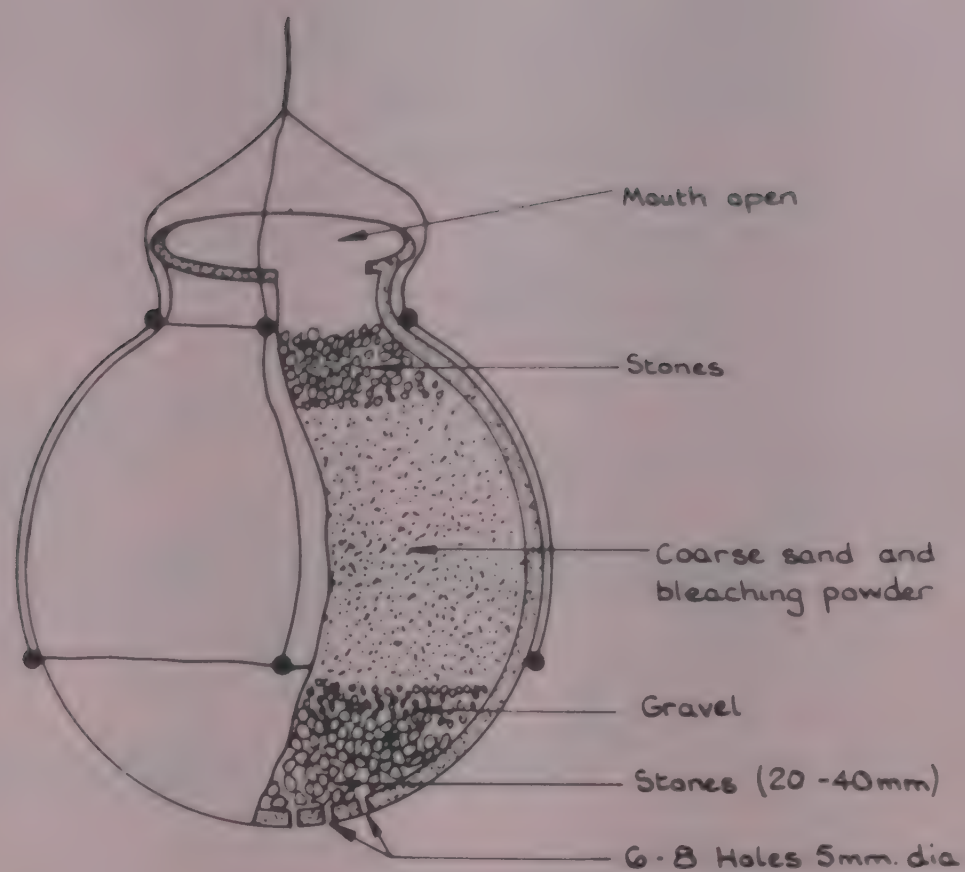
Fig. 8.6 The 3-pot system of water storage.

Fig. 6.14.

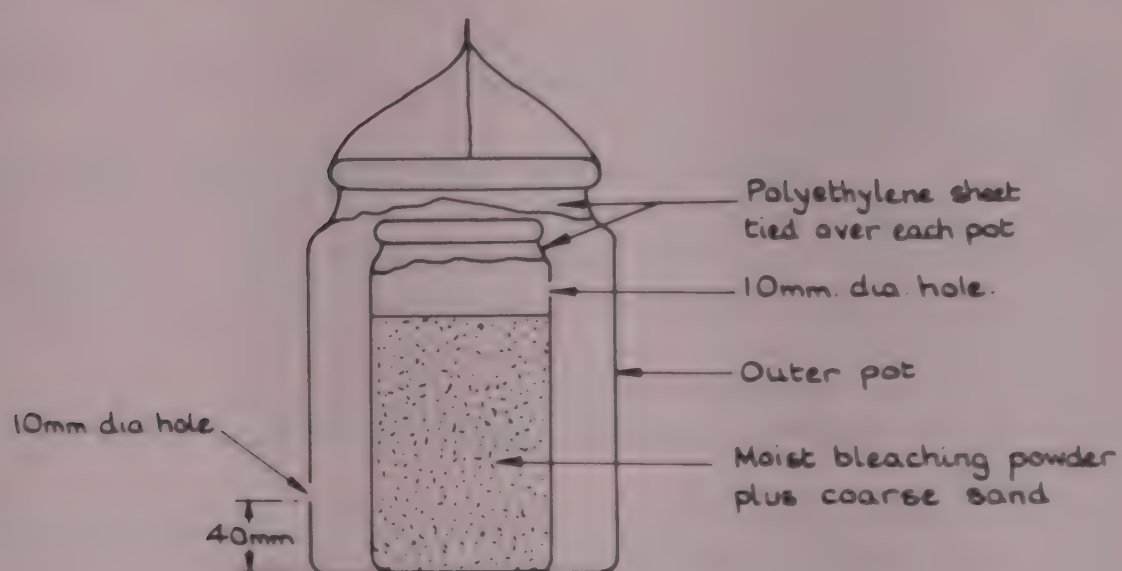
6.1.3. Water purification

See also the annotations in Section 1.1

Cairncross, S. and Feachem, R. (1978) Small water supplies.
Types of chlorinator are illustrated.



(a) SINGLE POT SYSTEM



(b) DOUBLE POT SYSTEM

Fig. 28. Pot chlorinators; two alternative designs.

Fig. 6.15.

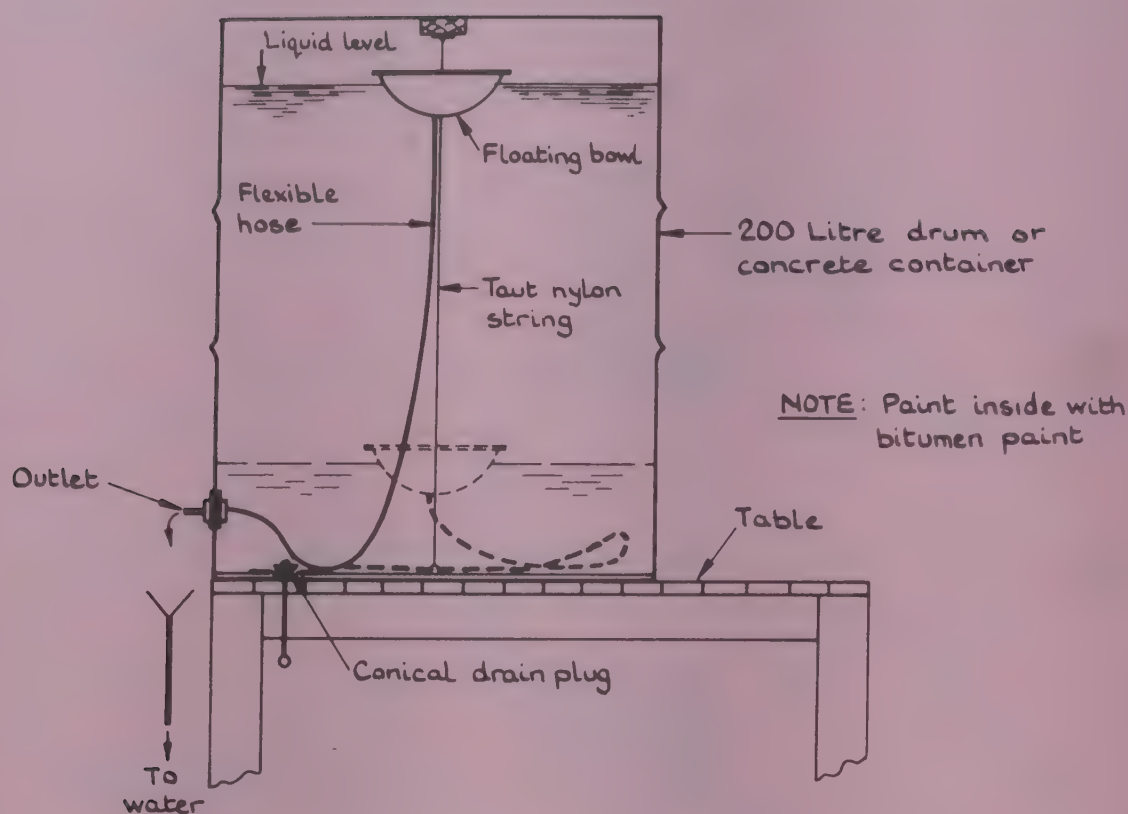


Fig. 29. Floating bowl chlorinator, to feed chlorine solution at a constant rate.
(From McJunkin).

Fig. 6.16

India, Ministry of Information and Broadcasting (1966) How to get safe drinking water.

"If there is no well and you are compelled to use water from a pond, lake or canal, strain the water through two layers of cloth and allow the water to stand for some time. The solid impurities will settle down and the clear water can be used after purification"

"Water will need purification, before you drink it, if it has been taken from a pond or canal, or even from a well, if the well is not clean.

You can purify water by any one of the following methods:

Boil the water 20 minutes. This is a reliable method to kill any disease-causing germs in the water.

Use fresh bleaching powder. This will kill any germs in the water. First dissolve one teaspoonful of bleaching powder in a glass (10 ozs) of water. Then, add three teaspoonfuls of this solution to one bucket (three gallons) of the water which is to be purified. Mix well and allow the water to stand for half-an-hour before use.

You can also use iodine to purify water. You can get iodine solution from any chemists' shop. Use two drops of this solution in a glass (10 ozs) of water to purify it"

"Having purified your drinking water, it is necessary to store it safely. Store the water in clean vessels and keep the vessels covered. Do not dip your hand when taking water out of these vessels."

TO AVOID DISEASE USE SAFE DRINKING WATER



Fig. 6.17.:Wood, C.H., et al. (1981) Community health: p.192

* IRC (1980s) Slow sand filtration; appropriate technology for safe water.

6.1.4.

Reducing the spread of schistosomiasis

Italy, Bologna (1977) Bilharziose. Prepared for Angola, Mozambique, Guinea Bissau and Cape Verde. Port. Well illustrated.

Philippines, Health Education Unit, Leyte (?1981) An sakit nga sistosomiyasis.

A useful 13pp. booklet including illustrations of a simple bridge across a small stream, latrine building, animal penning etc.

* Ross Institute (1979) Schistosomiasis. Bulletin No.6. Schistosomiasis has been mentioned since 1900 BC, in Egyptian records and it is still a major cause of ill-health in the developing world. This booklet introduces the problem of schistosomiasis - the life cycle of the parasite in man and the intermediate host (snails), and the clinical manifestations of the three types of schistosomiasis. The disease can pass unnoticed for several years until damage becomes advanced. Control of schistosomiasis is possible only after a preliminary survey: to locate the streams, ponds, swamps, ditches and rivers; to identify the snails that host the parasite; and to ascertain the types and intensity of the disease amongst people. Control depends upon: (1) prevention of human contact with infected water; (2) diminishing or eliminating the snails; (3) preventing the eggs from reaching fresh water through the use of health education (sanitary); and (4) treating human cases of schistosomiasis. Snails may be controlled through the use of molluscicide or eliminating their breeding places.

US, Centre for Disease Control (no date) Schistosomiasis.
A set of 39 slides from the People's Republic of China, showing posters, people working in rice paddies with canals, control of snails, altering streams, building a dyke to drain a swamp etc.

US, Dept. of Health, Education and Welfare (no date) Teaching aids library, Vol. 5: Schistosomiasis.
A set of 48 slides about: the clinical picture (7 slides), radiography (3 slides), microbiology (10 slides), pathology (7 slides), epidemiology (11 slides), intermediate hosts (3 slides), life cycle (1 slide) and special studies (6 slides) of schistosomiasis.

* WHO (1958) Schistosomiasis. 14 mins. colour. film. Eng. Arabic.

Schistosomiasis is caused by a parasite which at different stages of its development lives in snails and human beings. The disease abounds in areas where people have to spend much of their time working in muddy fields and in streams. The film shows how a team of international experts study this disease in the Philippines and seek to find means of bringing it under control. It also shows conditions that promote the spread of the disease and a number of dramatic examples of the suffering it causes. (Annotation from WHO).

6.2.

Safe disposal of waste water

Feachem, R.G., et al (1981) Five types of sullage disposal systems: pp 31-32. In: Health aspects of Excreta and Sullage Management: A state of the art review. Vol 3 of Appropriate Technology for Water Supply and Sanitation.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals.
Describes constructing a soak pit near the house, and waste water disposal, e.g. ways of dealing with run off from the toilet, bathroom or kitchen. Underground channels, or bamboo pipes can transfer waste water to a pit rather than letting it collect underneath the home.

* Wallis, S.I. (?1980) Making a soak pit, In FAO. Rural home techniques. Vol 6. Labour saving ideas. Series 3.

"What is a soak pit?"

A soak pit is a place to pour waste water. A hole is dug in the ground and filled with loose stones and gravel. It is made so water will seep quickly through the stones and run into the earth. When water is scarce, you may wish to use waste water for the garden, instead of pouring it into the soak pit.

Why make a soak pit?

When waste water is thrown out on the hard ground, it collects in little puddles. It may stand for days before it dries up or soaks in. This makes a muddy place where mosquitoes like to lay their eggs. Mosquitoes cause sickness.

You can place a dish-washing table or a laundry bench over a soak pit. Or you may build a soak pit under the shower.

Where should soak pits be located?

Place soak pits near where you wash dishes, take baths, and wash clothes. This will make it easier for you to pour waste water in them. Do not place soak pits near a spring or well..."

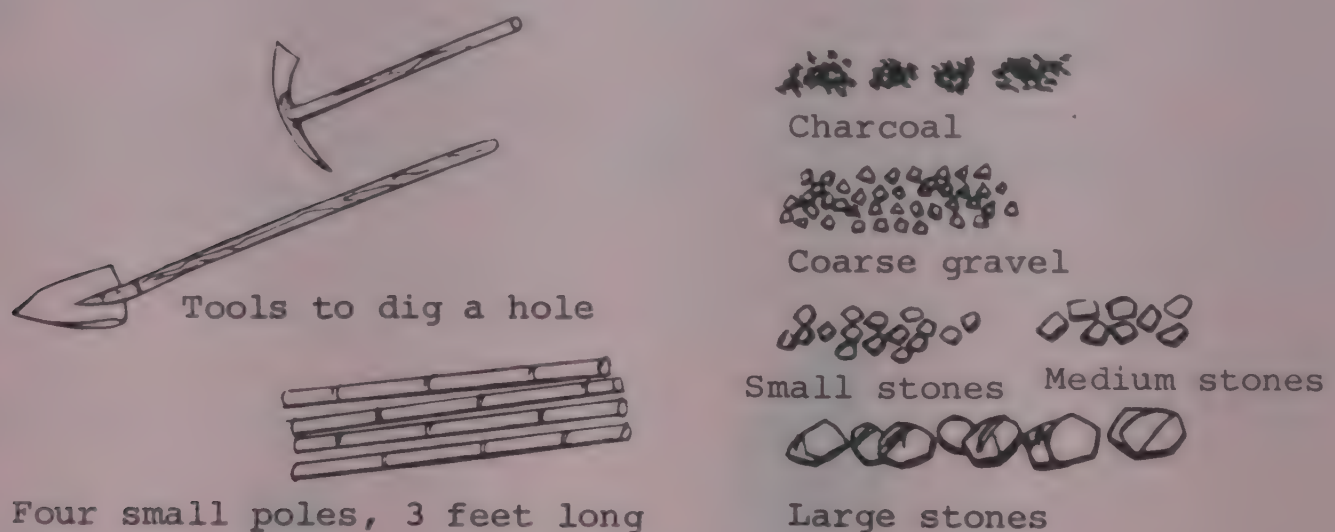


Fig. 6.18.: What you need to make a soak pit.

"How to make a soak pit

Step 1: Dig a hole 3 feet deep, 3 feet long, and 3 feet wide. If you strike a big rock so that you cannot move before you reach 3 feet deep, fill up the hole and choose another place.

Step 2: Place a layer of the largest stones in the bottom of the hole so they touch each other but do not overlap.

Step 3: Then place two or three layers of the medium stones on top of the large stones.

Step 4: Add small stones to almost fill the pit.

Step 5: Spread a layer of the smallest stones or coarse gravel on top. If you have charcoal, a last layer of charcoal will help to make the top smooth. Smooth the top so the centre is a little lower than the edges.

Step 6: Dig a small, shallow trench on all four sides of the pit, for the poles.

Step 7: Lay the poles in the trench and pack the soil around to make them firm. Leave the poles a little above the soil to make a rim around the pit. This rim will help to keep water from running off"

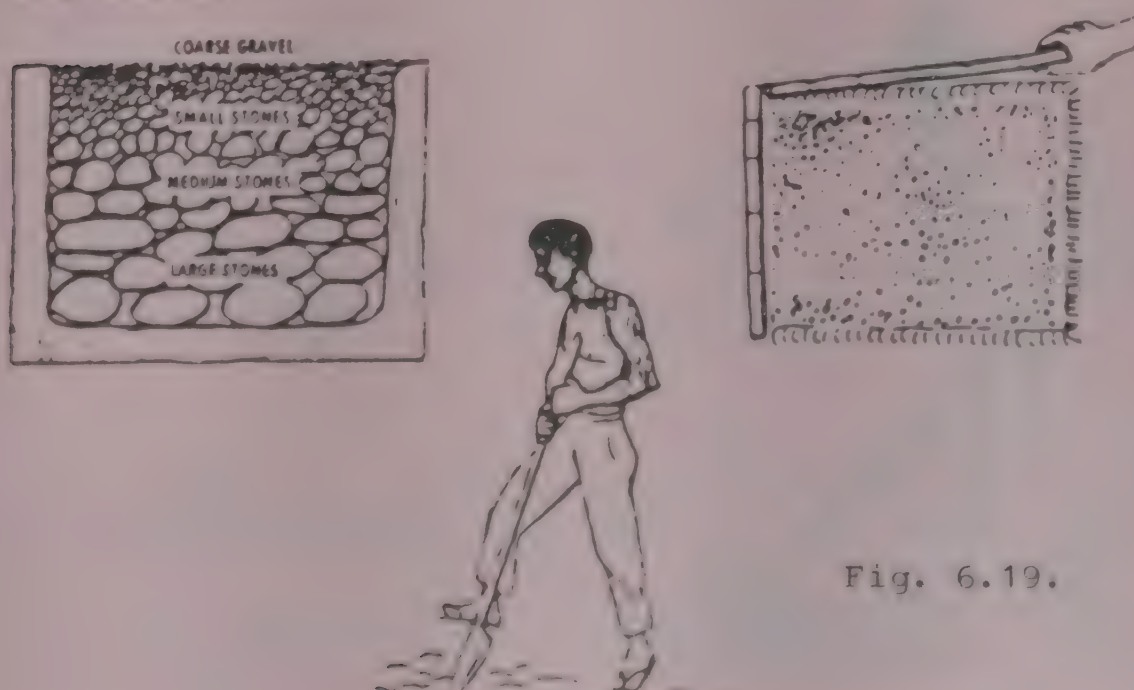


Fig. 6.19.

"Is one soak pit enough?"

Some families may need more than one soak pit.

Most of the waste water round the house comes from washing dishes, cleaning and scrubbing, washing hands, taking baths and washing clothes.

How many soak pits will you need to catch all this waste water? This will depend on how close together the places where you do the jobs are.

You may need two or more - one away from the house for the bath house and where you wash clothes, and one near the house to catch the waste water from dish-washing and cleaning"

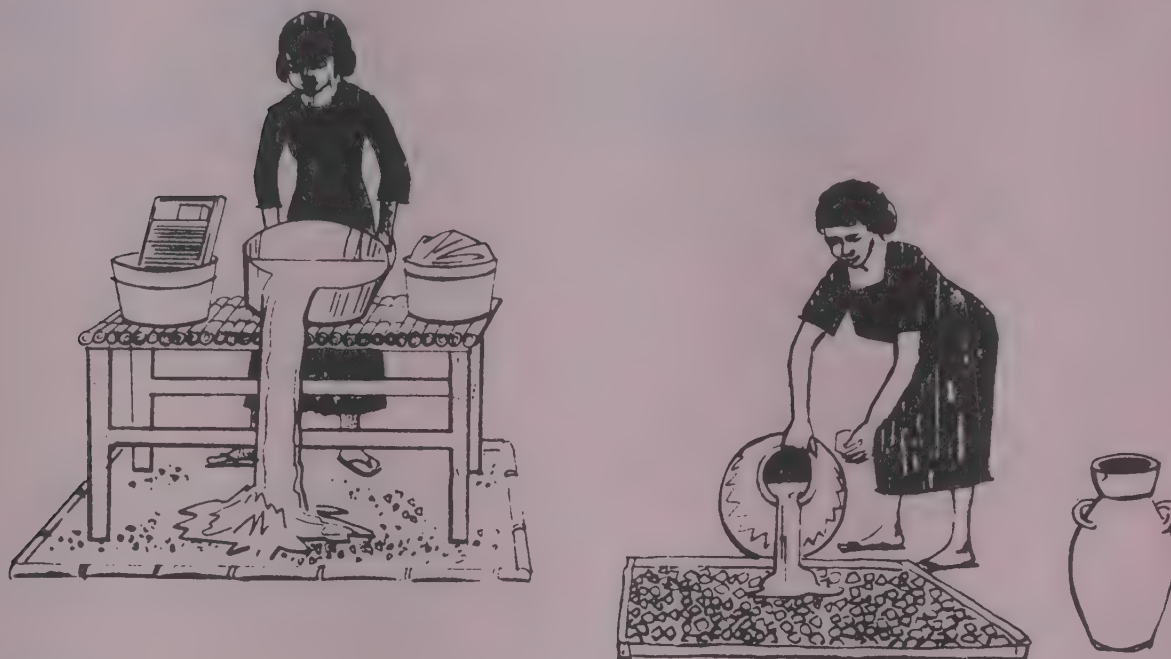


Fig. 6.20.

"How to keep a soak pit clean"

Do not throw peelings, waste food, or anything but water on top of the pit. These things will block it up so the water will not soak in. When grease collects on top, lightly scrape it off. Keep the top of the soak pit clean



Fig. 6.21.

"How to get people to make soak pits

To get families to make soak pits:

1. Find places where stones and gravel are available.
2. Get village families interested by talking to them about waste water - what they do with it and why waste water should not be poured out on the ground around the house."

6.3.

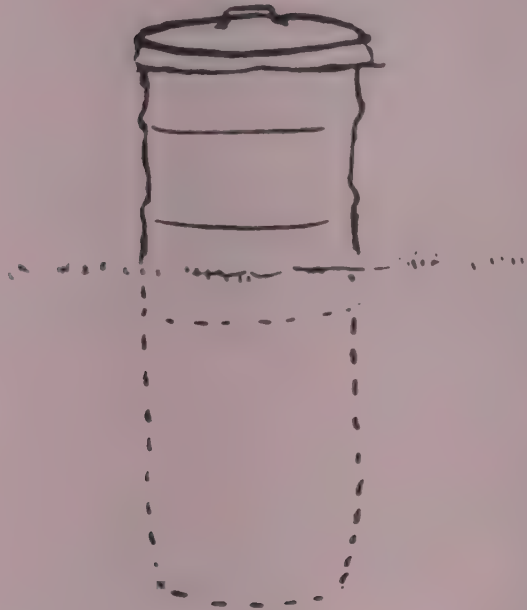
Safe disposal of solid waste rubbish (garbage)

Alaska, Dept. of Health (1956) Health and first aid guide for home and village.

"Pick up garbage and junk": either put in a covered pit or put in oil drums and haul away from village.

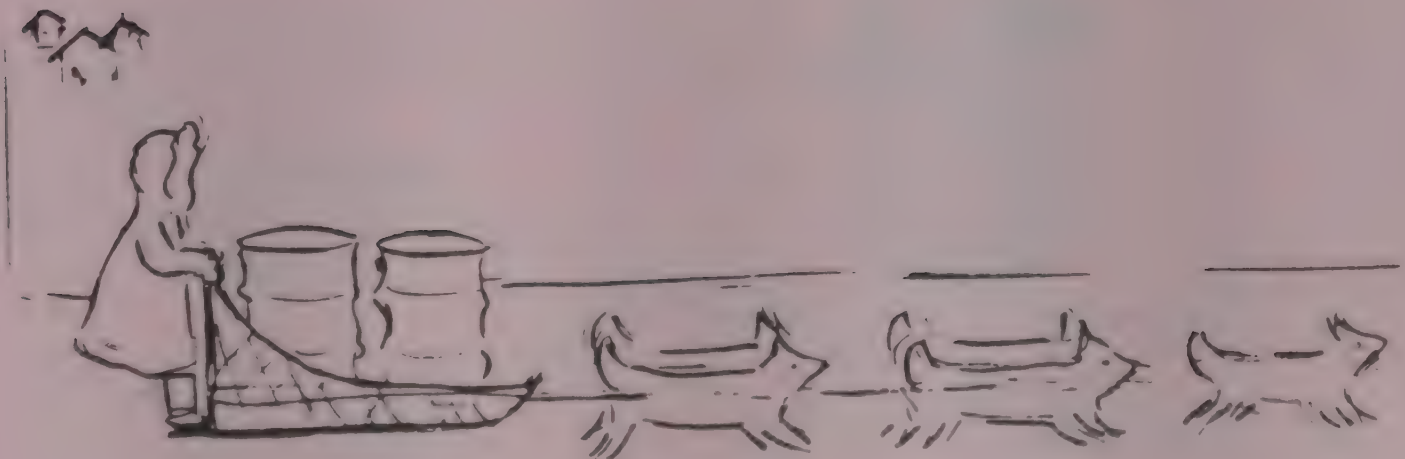
Use one of these ways to get rid of junk

1. Put in covered pit.



Knock bottom out of drum. Make lid and place drum over pit. Remove lid only when emptying garbage or junk. Flatten tin cans so pit will not fill so fast.

2. Put in oil drums and haul away from village



Keep village neat. Pick up tin cans, dead animals, junk. Put in one place where dogs and children cannot get at them.

Fig. 6.22.

* FAO (?1980) Rural home techniques: Labour saving ideas, Vol 6, Series 3. Eng. Fr. Sp.
4-page instruction leaflets on: Improved waste disposal - No. 3. Tin dustpans - No. 4.

Frelick, G. (1978) Health and sanitation lessons (Africa). A series of lessons on pregnancy; childbirth; how to monitor the growth and development of children; housing; personal hygiene; weaning foods; disposal of waste and garbage; conjunctivitis; malaria; colds; and immunisation. Unfortunately, there are no drawings, although the use of 'visual aids' in teaching is mentioned. The booklet appeared in French in Niger but was translated with little modification into English for use in the Gambia. Covers many subjects in only 90 pp.

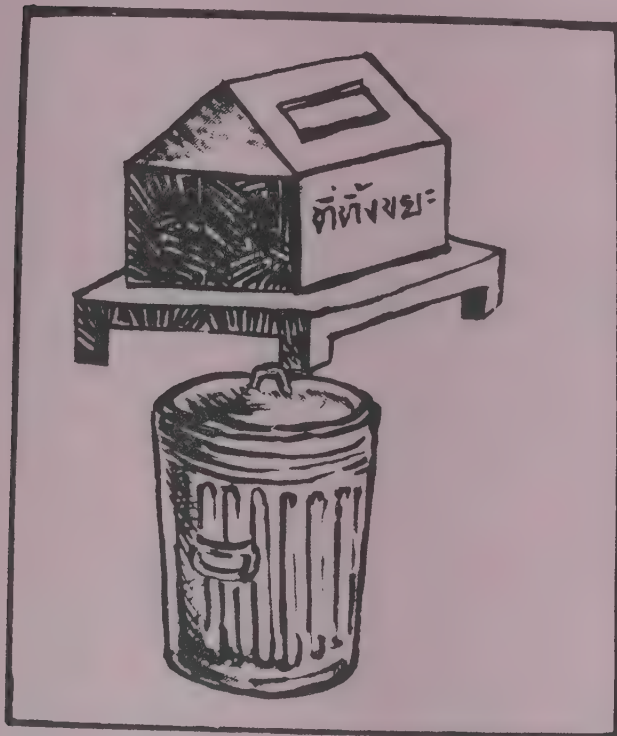
India, Ministry of Information and Broadcasting (1966) How to dispose of waste.

Queensland Health Education Council (?1960s) Keep it clean. Health Education Publication No. 129.

A leaflet emphasising the risks from rubbish; ill health; danger of accidents (glass, etc.); fire risks; and also the expense of council services.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals.

p.62: Garbage disposal: "Every house should have at least two garbage containers, if possible; one for dry garbage and one for wet garbage"



(a) "Dry garbage: e.g. leaves, waste paper, old rags. This garbage should be burned.

(b) Wet garbage: e.g. old bones, left over foods, and some types of dry garbage, e.g. cans, glass, metal. This garbage should be buried."

Fig. 6.23.

6.4.

Safe disposal of human waste (excreta, faeces)

* Alaska, Dept. of Health (1956) Health and first aid guide for home and village.

"Get rid of body wastes the right way" - a latrine made from an oil drum: p13.

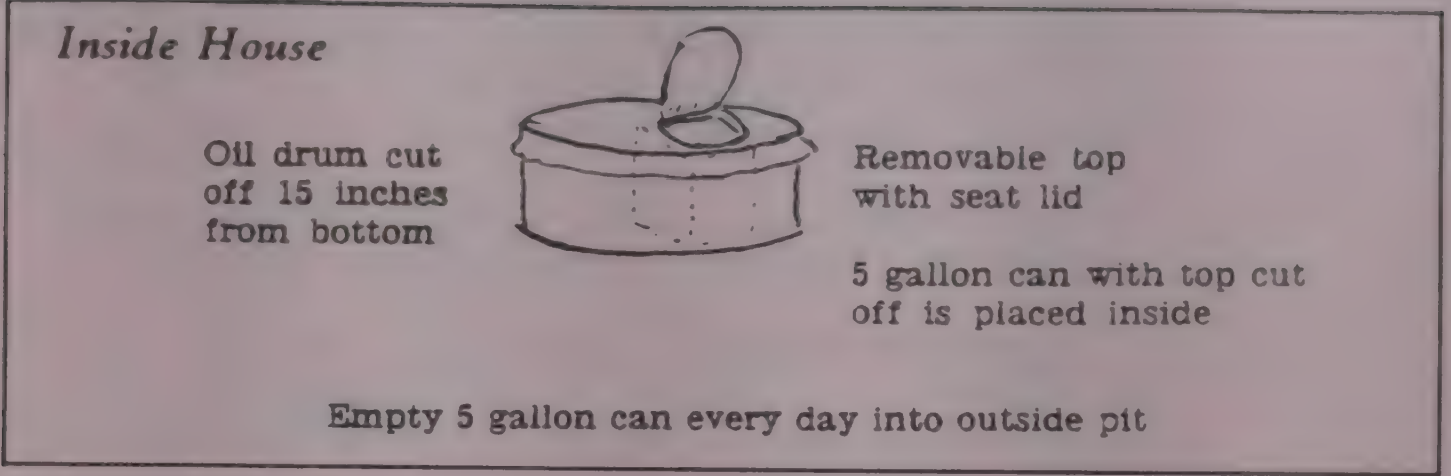


Fig. 6.24.

Outside House—Use one of these ways

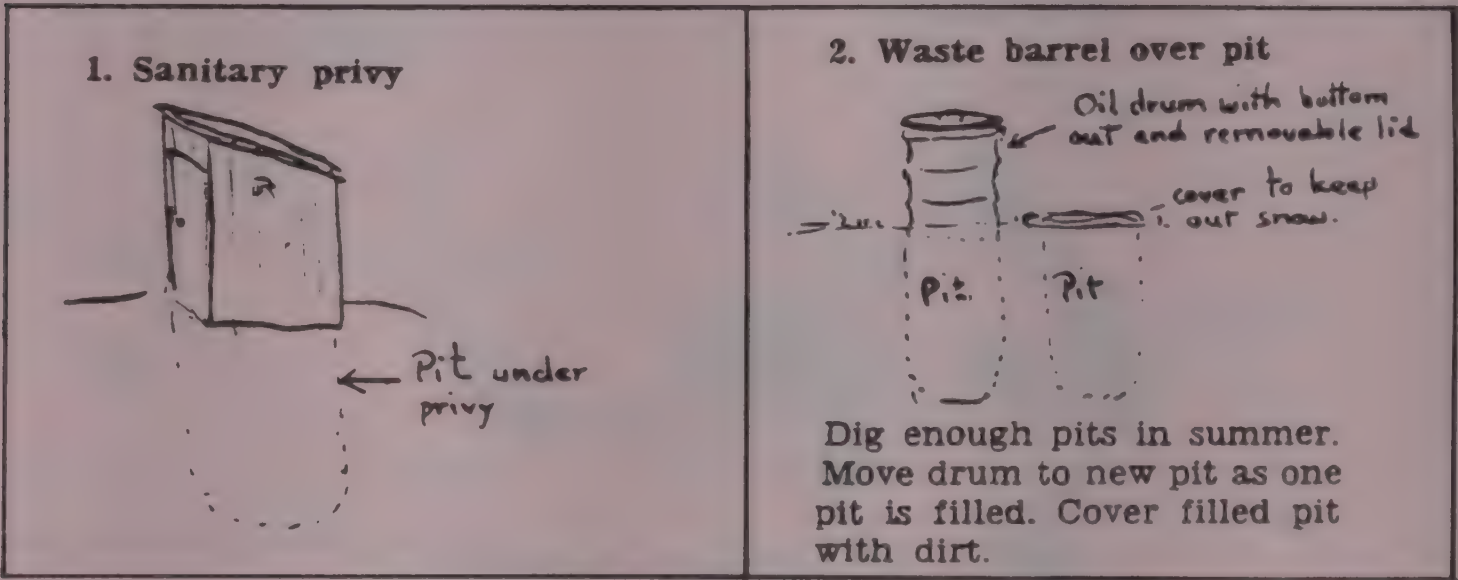


Fig. 6.25.

* AMREF (?1979) Illustrated tally sheet, Health happenings.

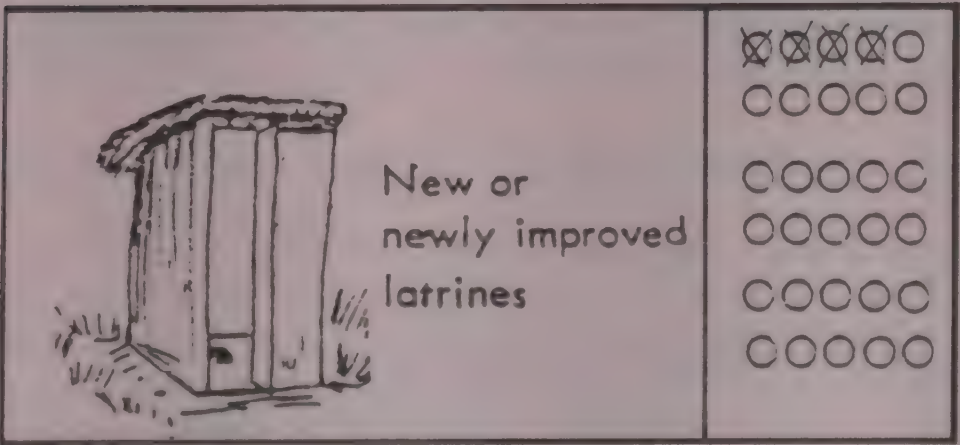


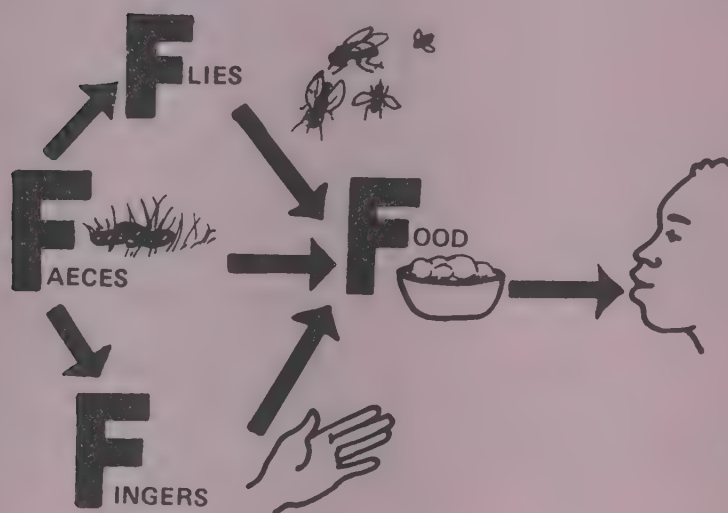
Fig. 6.26: "This is a record of things which you have seen happen. For each happening make a mark like this ⊗ in the proper place. When your leader comes, together count the ⊗'s and write the total and date of counting. This paper will give your work acCOUNTability".

* **APHA (American Public Health Association)** (1982)
Environmental sanitation and integrated health delivery
programmes. Monograph series No. 4.
Includes sanitary excreta disposal: p 68 ff.

* **Billington, R.** (1978) Health has many faces.
Sanitation (disposal of human waste): p 38 ff.

* **Diarrhoea Dialogue** (quarterly) Eng. Fr. Sp.? Port. Arabic
in future.
Frequently includes ideas on latrines from many countries.

* **Eshuis, J. and Monschot, P.** (1978) Communicable diseases.
Chapter 4: Diseases caused by faecal contamination: p. 131.
Includes cholera, diarrhoeal diseases, amoebiasis, typhoid,
poliomyelitis, food poisoning, viral hepatitis. The manner in
which these are spread is explained with illustrations. Special
attention needs to be paid to oral rehydration therapy and a clean
water supply.



The rule of F.

Fig. 6.27.

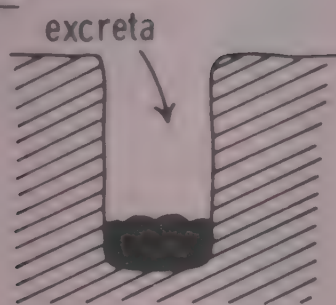
Feachem, R.G. et al (1981) Health aspects of excreta and
sullage management: A state of the art review. Vol. 3 of
Appropriate Technology for Water Supply and Sanitation.

Feachem, R. and Cairncross, S. (1978) Small excreta disposal
systems.

Written for people with at least secondary education, the booklet
describes the range of technologies available for excreta disposal
in small communities and describes each system in simple terms.
The booklet is divided into sections: (1) medical and social
perspective - "the sanitary disposal of human wastes is perhaps of
greater importance than the provision of safe water supply"; (2)
the elements of the system-deposition (squatting), collection
(pit), transportation (vacuum truck), treatment (ponds)
transportation (discharge), re-use (fertilisation); (3) complete
sanitation systems-pit latrines, bucket and cartage systems, vault
and vacuum truck systems, aquaprivy systems, septic tank systems,
etc., with a table of comparison of cost, rural/urban application,

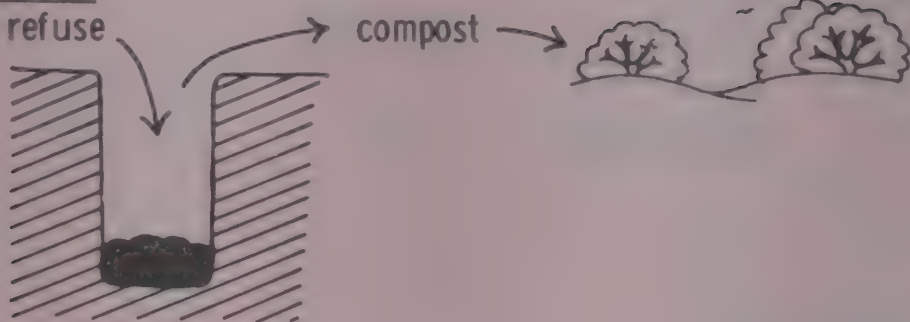
hygiene, etc.; (4) design and construction.

PIT LATRINE



COMPOSTING PIT

excreta + refuse



BUCKET WITH COMPOSTING

excreta

excreta



refuse

compost



composting
or digestion



BUCKET WITH AQUACULTURE

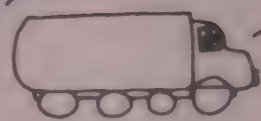
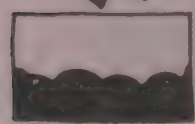
excreta

excreta



VAULT

excreta



refuse

compost



composting



Fig. 14. Pictorial representations of various excreta disposal systems.

(a) 'Dry' or nightsoil systems.

Fig. 6.28: Feachem, R. and Cairncross, S. (1978) Small excreta disposal systems: p.18.

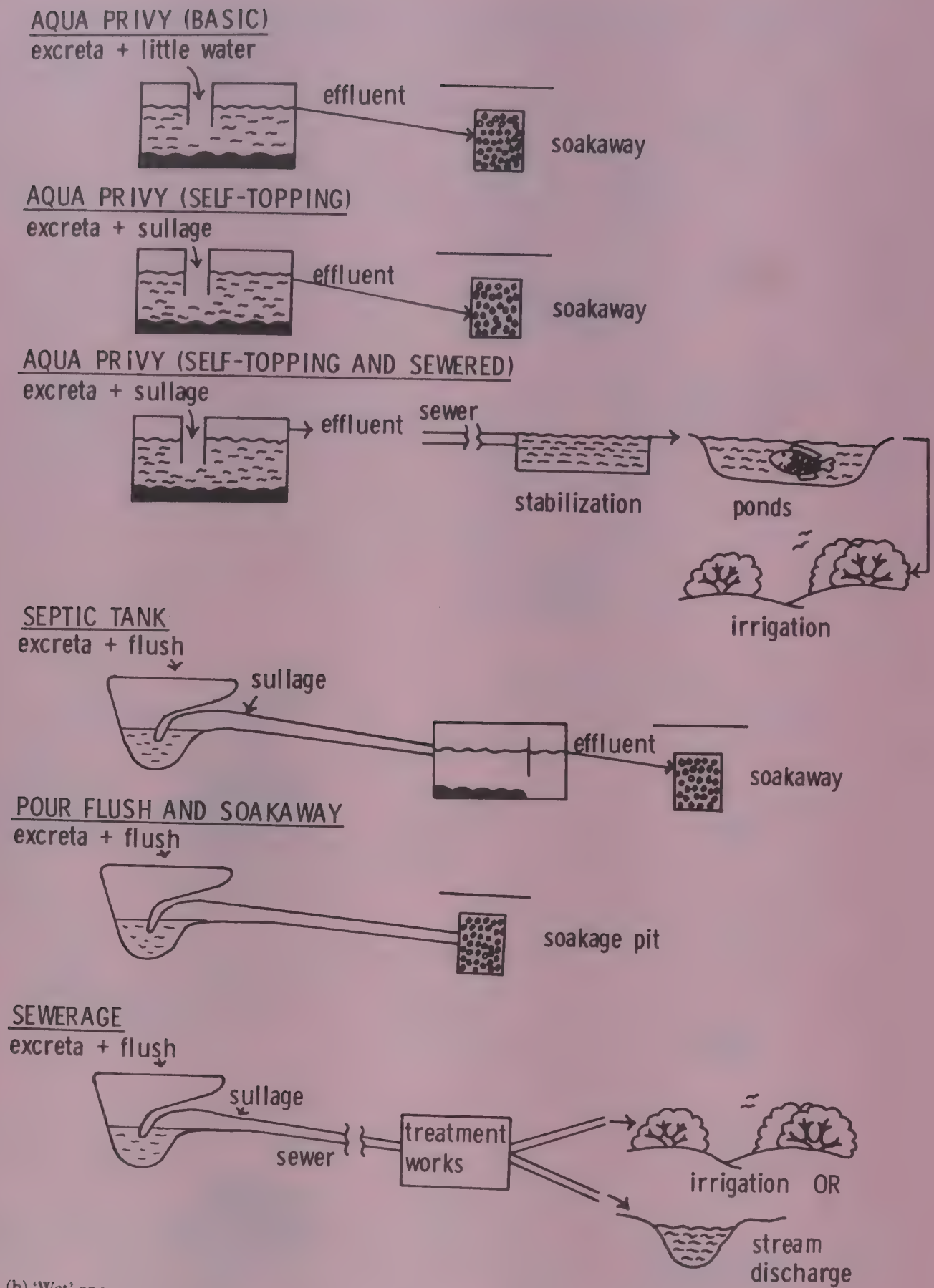


Fig. 6.29: Feachem, R. and Cairncross, S. (1978) p.19.

TABLE 2: Comparison of Several Sanitation Technologies

Sanitation System	Rural Application	Urban Application	Construction Cost	Operation Cost	Ease of Construction	Water Requirement	Hygiene
Pit latrines	Suitable in all areas	Not in high density suburbs	Low	Low	Very easy except in wet or rocky ground	None	Moderate
Bucket and cartage	Suitable	Suitable	Low	High	Easy	None	Bad
Vault and vacuum truck	Not suitable	Suitable where vehicle maintenance available	Medium	High	Requires skilled builder	None	Moderate
Aqua privies	Suitable	Suitable	High	Low	Requires skilled builder	Water source near privy	Good
Septic tanks	Suitable	Suitable for low-density suburbs	Very high	Low	Requires skilled builder	Water piped to privy	Excellent
Pour flush and soakaway	Suitable	Not suitable	High	Low	Requires skilled builder	Water source near privy	Good
Sewerage	Not suitable	Suitable where it can be afforded	Very high	Medium	Requires experienced engineer	Water piped to privy	Excellent

Fig. 6.30: Feachem, R. and Cairncross, S. (1978) p.27.

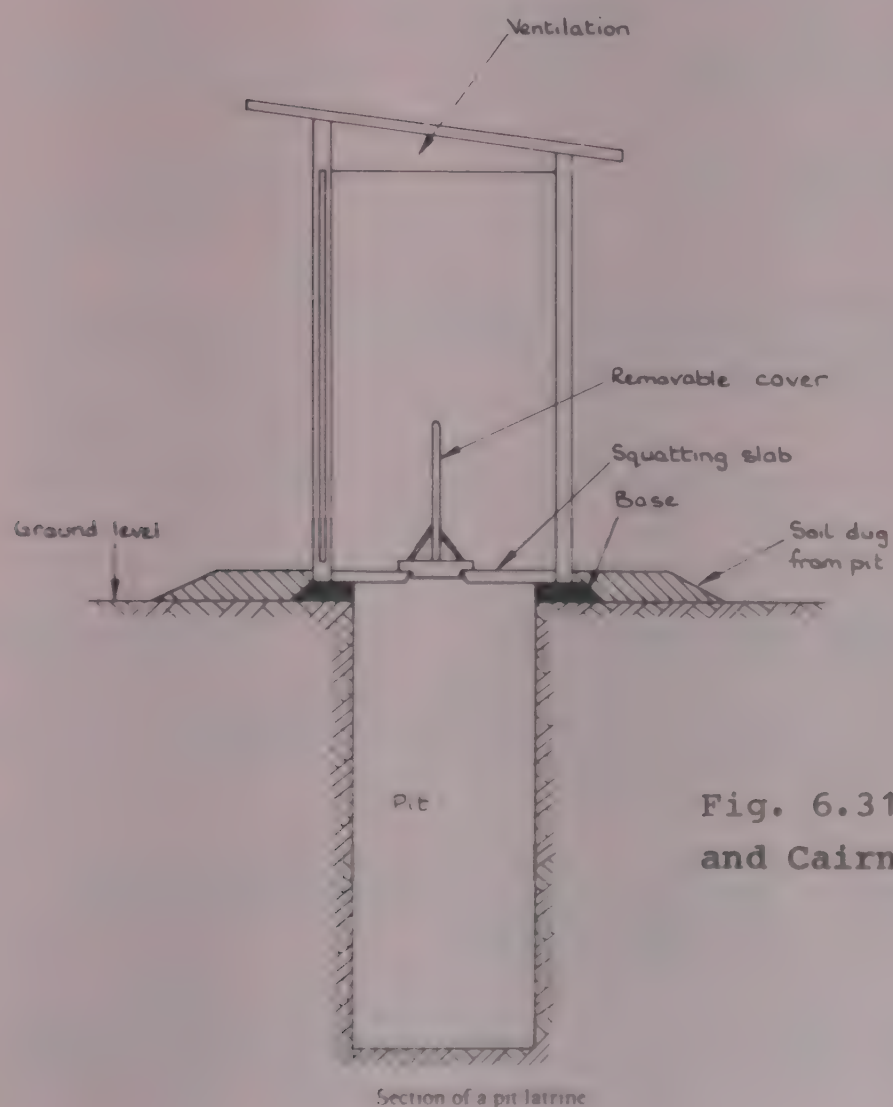


Fig. 6.31: Collection. Feachem, R. and Cairncross, S. (1978) p.6.

Fiji, Medical Department (1967) Manual of rural hygiene. Shows the superstructure for a latrine: p.12 and fig.8.

* Frelick, G. (1978) Health and sanitation (Africa).

Glimpse, Newsletter of the International Centre for Diarrhoea Disease Research, Bangladesh (1981) Children's stools, why it matters most! 3 (4): p.2.

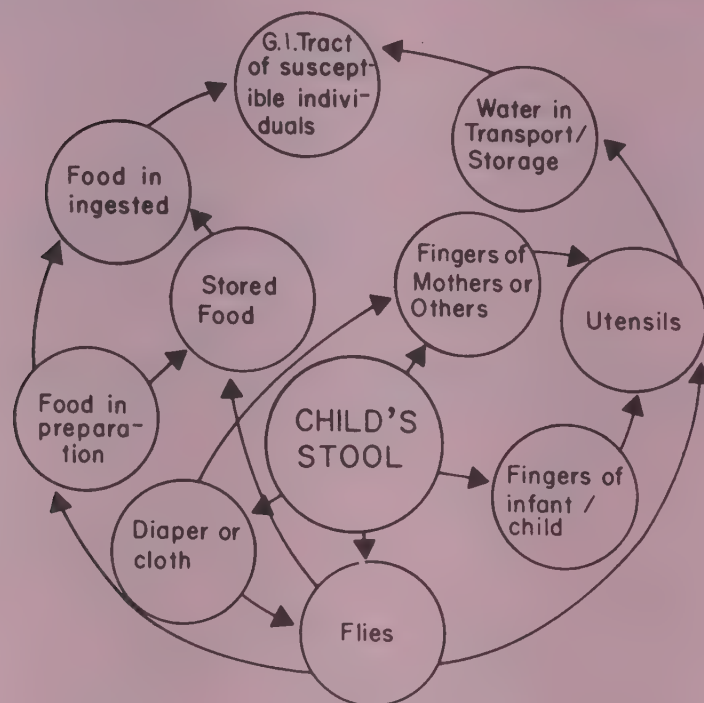
The report of a seminar on children's stools.

"The stool of a child is dangerous because it contains more germs per unit of weight of stool than an adult. For this reason children deserve special attention in planning and execution of sanitation programmes." Conveniently located child sized latrines are suggested.

Based on a seminar given by Dr Raymond B Isely, Associate Director, WASH at the ICDDR,B on 6th March 1981

Targeting Sanitation Programmes where it counts:

Mothers and Small Children



CYCLE OF CONTAMINATION OF THE ENVIRONMENT
THROUGH THE STOOLS OF INFANTS
AND SMALL CHILDREN

Fig. 6.32.

* Health Education Council, UK (1972) Housefly poster.

Hughes, K.S. (?1970s) Comment se debarrasses des ordures. Fr. 15pp. Illustrated booklet.

* IDRC (1978) Low cost technology options for health manpower and sanitation - annotated bibliography and review. IDRC 102e. Contains many useful references.

* McMichael, J.K. (?1973) Health in the third world. Studies from Vietnam.

Chapter on the double septic tank.

* **Mauritius, Ministry of Health** (1982) Health education material: posters, pamphlets and flannelgraphs.

Posters:

(1) Environmental sanitation; (2) Nutrition (breastfeeding); (3) Immunisation (schedule); (4) Social hygiene (smoking), alcoholism; (5) Family planning.

Pamphlets:

(1) Environmental sanitation (flies, mosquitoes, bilharzias, worms); (2) Social hygiene (VD, drug addiction, alcoholism); (3) Nutrition (breastfeeding); (4) Family planning (for parents).

Flannelgraphs (MCH)

(1) Antenatal care; (2) Post-natal care; (3) Nutrition; (4) Common diseases of childhood.

Textbooks (primary and secondary schools):

(1) Home economics I-III - emphasis on food, hygiene, food preservation, food hygiene, first aid; (2) Integrated science I-III (11-13 year olds) - Environment, pollution, nutrition, reproduction, etc.; (3) Primary school trial material standard I (5-6 year olds) - Nutrition: What do I eat and drink? What food does the baby take?

Mozambique, Ministry of Health (1977) Textos de educacao sanitaria; O minimo higienico das aldeias comunais; Relecao dos medicamentos e artigos e penso a serem utilizados por tecnicos e agentes de medicina. Port.

* **Niger, Ministere de la Sante, direction des affaires sociales** (1974) Flannelgraphe a l'usage des PMI (Projets Maternelle et Infantile) pour l'education sanitaire et sociale. Fr.

* **Nimpuno, K. et al** (1981) Documentation on low cost sanitation.

* **Pisharoti, K.H.** (1975) Guide to the integration of health education in environmental health programmes. WHO Offset Pub. No. 20. 81 pp.

Written for environmental health planners and administrators, to enable them (a) to incorporate community-oriented health education; (b) to develop programmes for environmental health teaching among school children. This would then enable community participation in planning, acceptance, utilisation of facilities. The guide is divided into 3 sections:

(1) health education in environmental health programmes - deals with objectives, data gathering and analysis and the framework for planning an integrated approach; (2) training and supervision; and (3) environmental health education in schools.

Each section in (2) and (3) includes teaching methods, targets and evaluation of the programmes.

* **Ross Institute** (1979) The housefly and its control. Bulletin. No. 5. Revised edition.

Two methods of approaches to fly control are described: control of breeding (sewage disposal, disposal of animal manure, disposal of refuse and garbage); and control of flies by destruction (swatters, traps, contact insecticides, residual fumigants, poison

baits, larvicides, etc.). The bulletin also points to necessary precautions in the use of insecticides.

* **Thailand, Ministry of Health** (1981) Community health volunteers' nutrition and health work manuals. Sanitation: pp 60-61.

* **UNICEF** (1981) Waterfront, Issue No. 27.

Includes a letter asking "Are latrines the answer?". Reports on an unpretentious practical study in a rural community in India. The study revealed to the organiser "that my approach had been wrong".

"I had preached the need of using a latrine in order to prevent disease such as parasite infestation, while people are motivated more by aesthetic and convenience values than by good public health".

Here are her results from one village in India:

Total number of people interviewed: 39 (12 adult women; 4 girls; 13 adult men; 10 boys). Of these 39, only one boy and one man used a latrine for defecation (5% of total).

Four women (10%) have a gutter drain in their house for urinating but go to the open for defecating.

The most common place of defecation is the open field (56%) and then indiscriminately anywhere (31%).

The main reasons for using the open field were given as:

- "to be in the open air" 33%
- "no smell" 31%
- "more comfortable" 21%
- "clean" 13%
- "private" 13%

As to latrines, there were several opinions:

- "smelly" 26%
- "unclean" 21%
- "we do not like latrines" 18%
- "I've never heard of a latrine before" 44%
- "a latrine is not necessary" 31%
- "it costs too much" 21%
- "a latrine is only for rich people and not for those who live in a mud house" 8%

Knowledge of harmfulness and/or usefulness of human excreta as expressed by the 25 adults:

- "human excreta are harmful" 92%
- "human excreta are harmful but also useful" 72%

There is a duality of perception in the adults' realisation that human excreta can be a danger (cause disease) and be of use (as fertiliser for agriculture).

What adults think of children's excreta:

- "children's excreta are not harmful" 32%

but no one finds adults' excreta harmless.

Would adults like to have a latrine in the home?

Most of those who said yes, they would like to have one, had definite reasons:

- "good to have a latrine in the home during sickness" 83%
- "needed during the postnatal period" 75%

The preference is thus not for regular use but for special situations, when one is unable to go to the field or outside. The advantage is not seen in terms of prevention of sickness but in

terms of convenience.

Main reasons for not wanting a latrine in the home:

- "it is smelly" 83%
- "unclean" 67%
- "don't like it" 42%

The major objection is for aesthetic rather than for health reasons.

The one man who built and used a latrine said that "it is cleaner, private, might prevent illness and is nearer". He thought that people who do not use a latrine "are very poor and probably lack space in their home for one." His own one is a water-seal latrine with no smell.

All the other adults who had not built a latrine said:

- "do not like latrines" 33%
- "latrines are not necessary" 46%
- "latrines are smelly" 33%

Other reasons:

- "latrines cost too much",
- "we have no space",
- "we have no water",
- "latrines are dirty",
- "latrines are dangerous for children".

Only one out of 14 children had a latrine in his home. Of the 13 children without one:

- 5 said they would use a latrine if they had one.
- 8 said no.

"In some tropical areas of Bolivia the water table is so high that one must build a high mound of earth on which to dig a simple latrine. What family is going to go through all that work? It is so much simpler and more private to just disappear into the banana plantation for a few minutes. In another tropical area the school teacher has a thriving fish pond in the centre of the village. When the idea of a latrine built over the fish pond (Indonesian fashion) was presented, the villagers were scandalised. Yet anaemia, intestinal parasite infestations, diarrhoeas, and vomiting flourish and are the chief causes of disease and death in these areas. Again and again I question if the people could not be taught to simply cover their excreta?"

*** USAID WASH (Water and Sanitation for Health Project)**

The project is preparing a bibliography of water and sanitation related health education materials created and produced in developing countries.

*** VITA (1978) Village technology handbook: pp.147-167.**

Sanitary latrines (pit latrines and water privies) are explained in detail. Simple inexpensive constructions are recommended. The location of the privies should be near the home, but they should not contaminate surface or ground water. They should be sheltered from flies, rain and kept clean. The construction of a pit is detailed with diagrams.

*** Werner, D. (1977) Where there is no doctor.**

Contains many very useful sections, including Better latrines: pp137-139; Transmission of disease from faeces: p.132.

*** Winblad, U., Kilama, W. and Torstensson, K. (1978)**

Sanitation without water. 116pp.

Excellent illustrations of the transmission of disease via faeces. A useful practical manual covering: why excreta disposal is a problem; descriptions of infections (from water, soil, insect vectors and tapeworm); examples of sanitation without water; and a section on how to build a latrine, with operating instructions and fly control methods.

The examples of sanitation without water include: the Chinese "four in one" composting; the Vietnamese double vault latrines; Indian compost latrines; Swedish muldrum toilets; Yemeni long drop toilets; Algerian single vault compost latrines; Tanzanian pit latrines; US earth pit privies; Egyptian bore hole latrines; and South African Reid's odourless earth closets.

INFECTION FROM INGESTION OF FOOD OR DRINK CONTAMINATED WITH FAECES

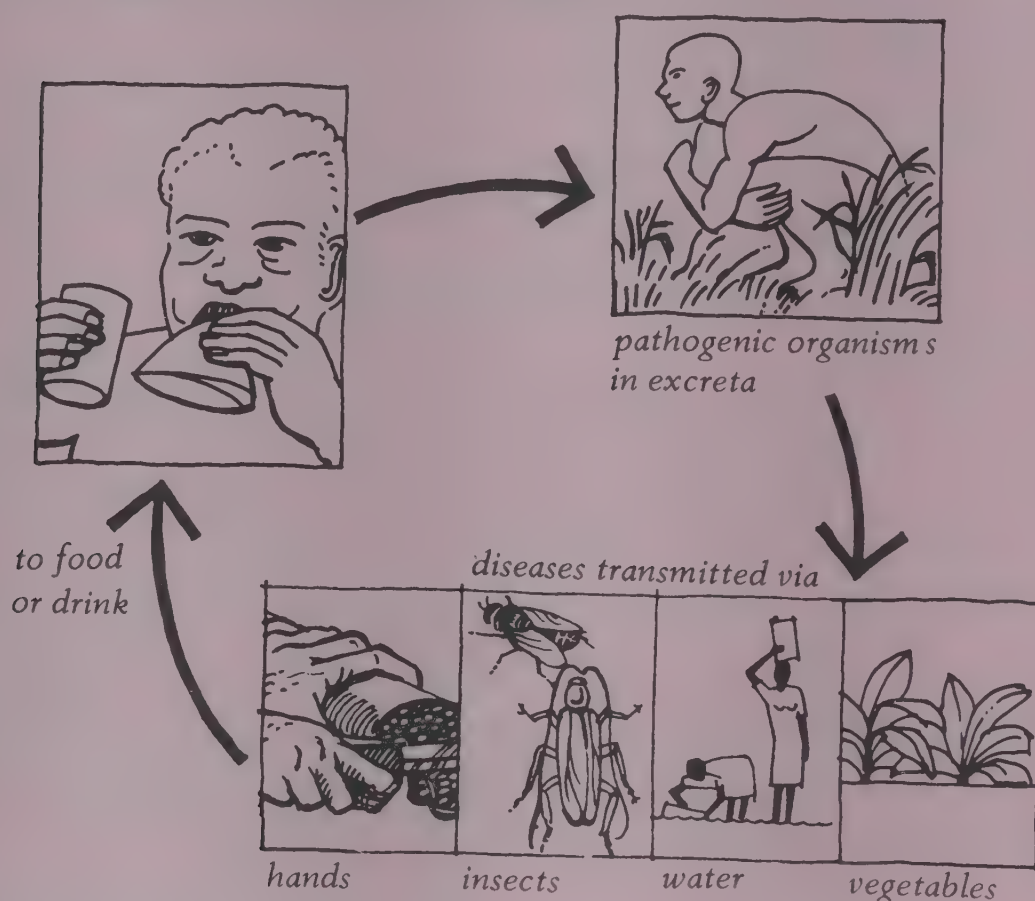


Fig. 6.33: Winblad, U. et al. (1978) Sanitation without water: p.7.

CHINA: "Four into One" composting

Composting of human and animal excreta has been practised in China for thousands of years. In 1952 an estimated 70% of all human excreta produced in China were collected and used as fertilizer. In 1956 this figure had been pushed up to an unbelievable 90%, altogether some 300 million tons (Dorozynski 1975). At the time that represented about one third of all fertilizers applied in the country.

In rural areas the latrine was often combined with a pig-pen in such a way that the pigs could feed on human excreta.



Figure 11

Fig. 6.34: Winblad, U. et al. (1978) Sanitation without water: p.24.

The Vietnamese latrine consists of two receptacles, each with a volume of about 300 litres.

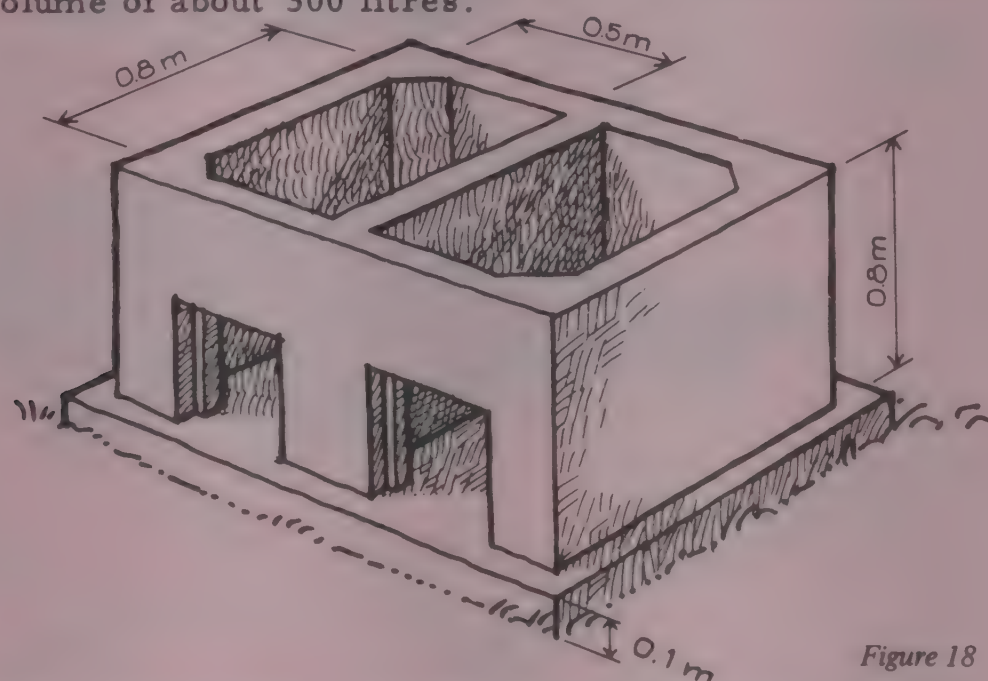


Figure 18

It is built entirely above ground with the two receptacles placed on a solid floor of concrete, bricks or clay. The floor must be at least 0.1 m above ground, so as not to be flooded by heavy rains. The latrine should be located at least 10 m away from dwelling houses and water tanks.

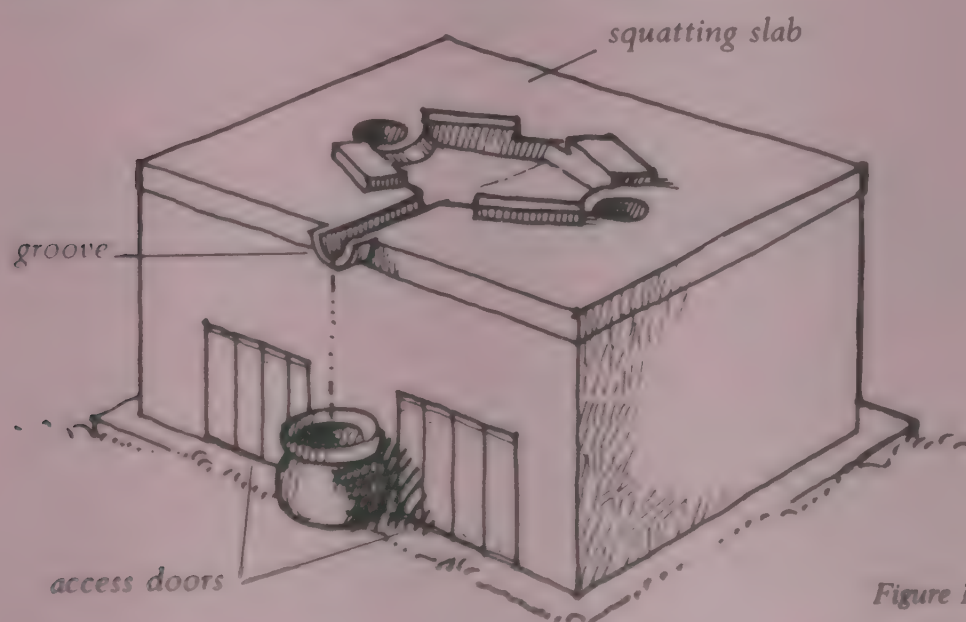


Figure 19

Fig. 6.35: Winblad, U. et al. (1978) Sanitation without water: p.30.

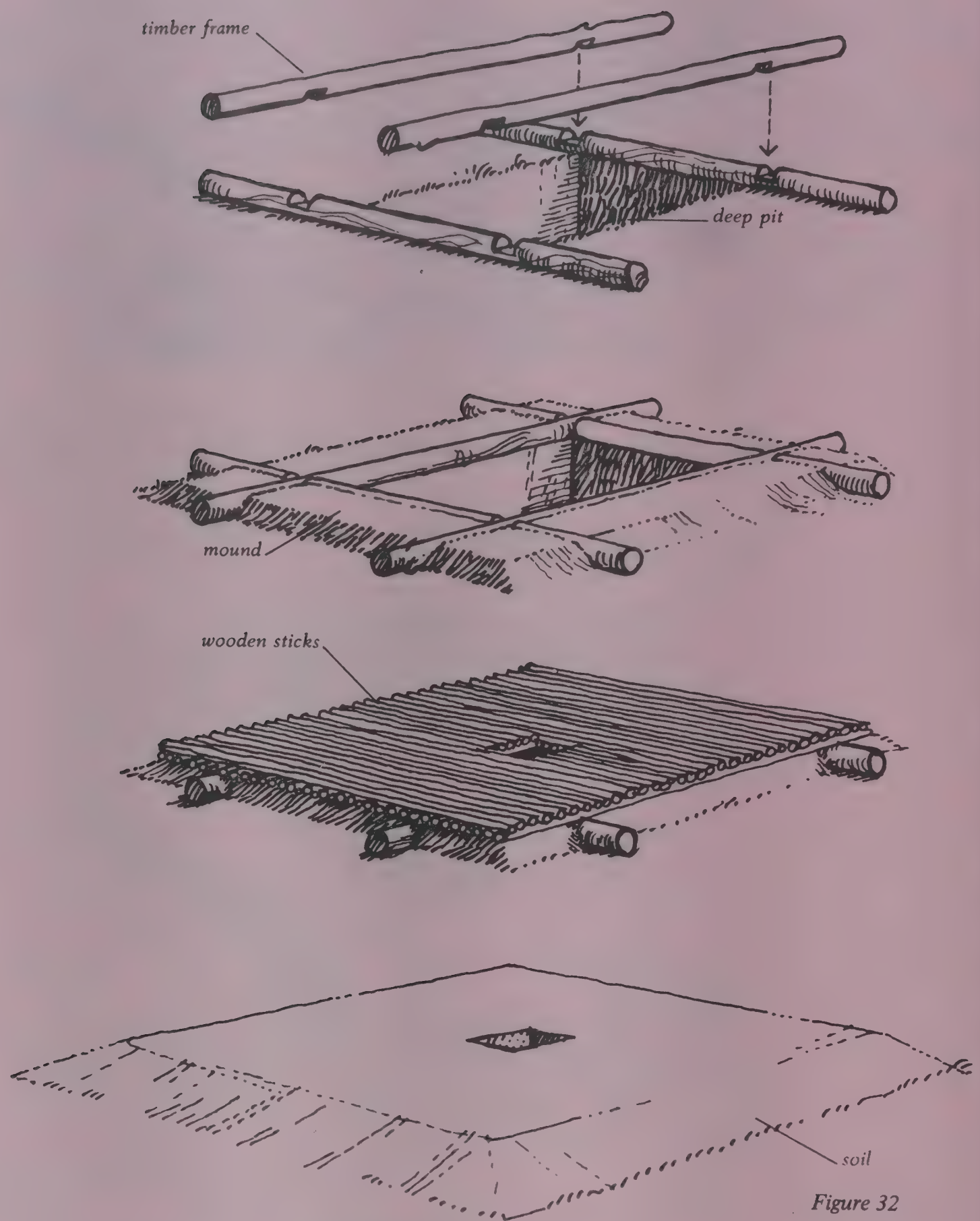


Figure 32

Fig. 6.36: Tanzania: the traditional pit latrine. from
Winblad, U. et al. (1978) Sanitation without water: p.51.

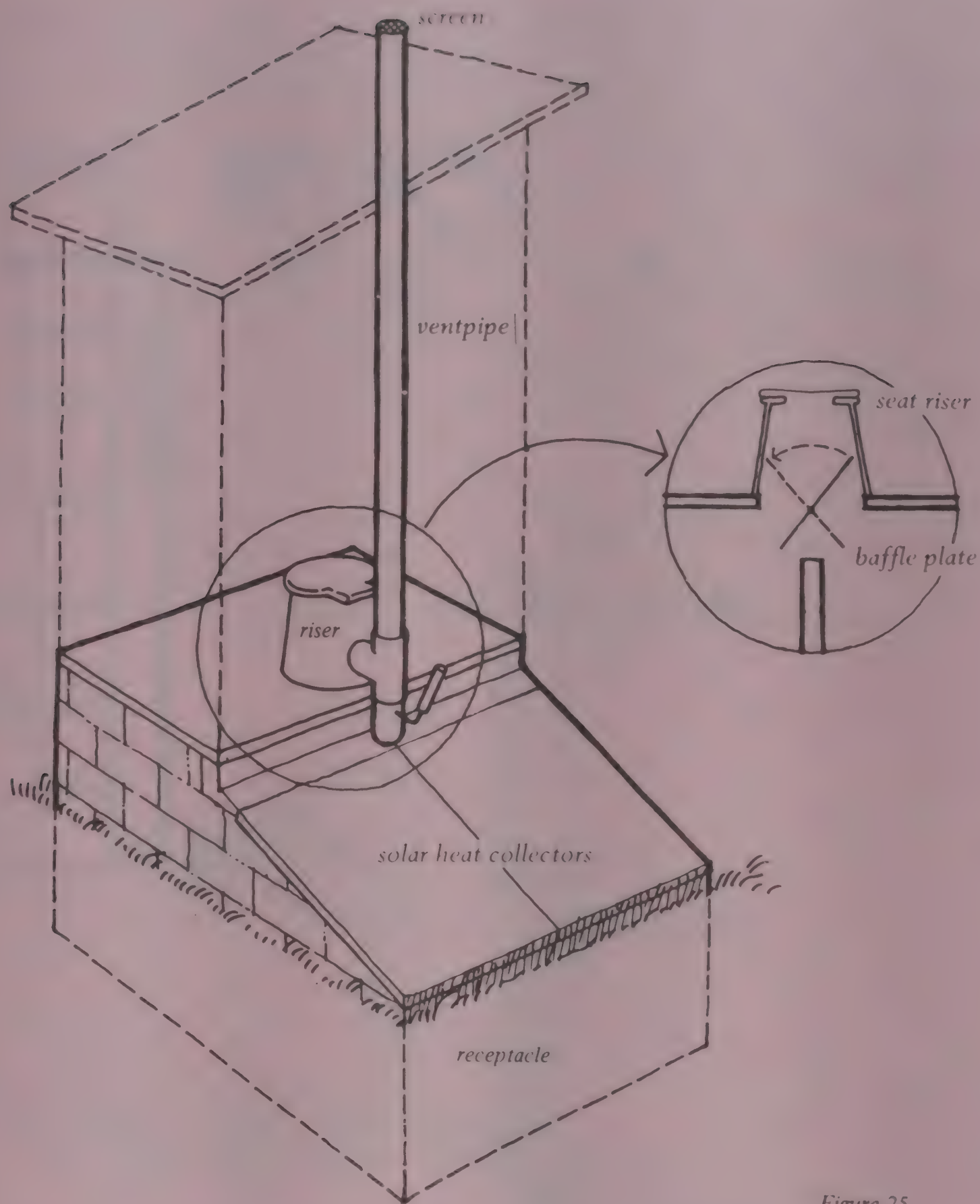


Figure 25

Fig. 6.37: Mexico: the solar heated, double vault compost latrine.
 from Winblad, U. et al. (1978) Sanitation without water: p.39.

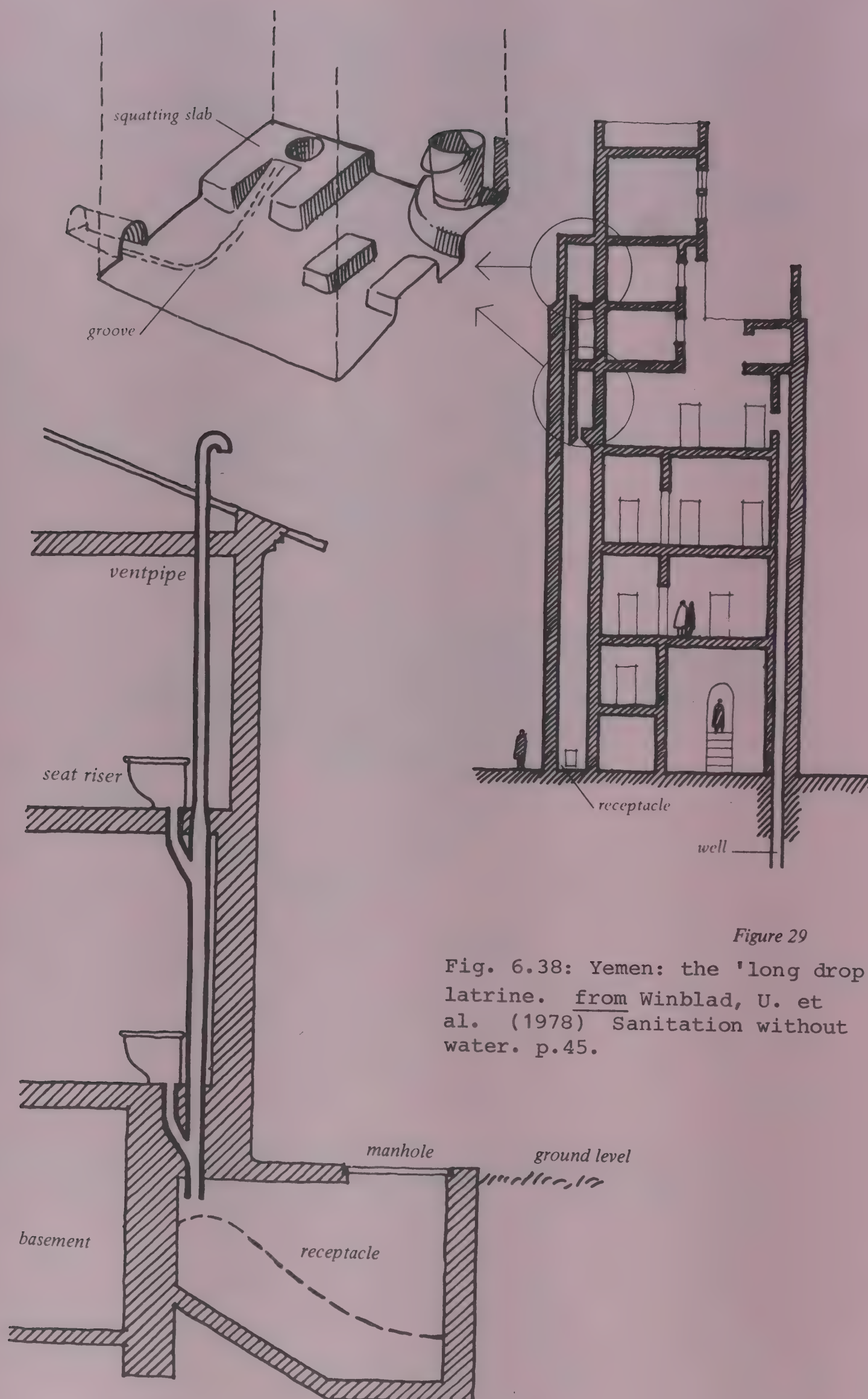


Figure 29

Fig. 6.38: Yemen: the 'long drop' latrine. from Winblad, U. et al. (1978) Sanitation without water. p.45.

Figure 31

Fig. 6.39: West Germany: the 'long drop' latrine. from Winblad, U. et al. (1978) Sanitation without water. p.49.

World Bank (1982) Appropriate technology for water supply and sanitation, sanitation alternatives for low income communities, a brief introduction.

* World Bank/UNDP, Technical Advisory Group (TAG) (1983) Pit latrine ventilation: field investigation methodology. Technical Note Series No. 4.

World Bank/UNDP, Technical Advisory Group (TAG) (no date) The ventilated improved pit latrine (VIP latrine). The VIP latrine design is constantly being updated, and technical notes can be obtained from Richard Middleton, Project Manager, UNDP INT/85/047, WUDOR, The World Bank, 1818 H St. NW, Washington DC, 20433, USA. A very successful new design. The superstructure is a doorless spiral with a large external vent pipe. The lack of a door means the latrine can always be kept dark - very important for fly control. Any flies that do manage to get into the pit escape via the external vent pipe. Ventilation is improved by the vent pipe and by the absence of a cover for the squat hole. Covers can become contaminated. The superstructure comes in a kit for \$100,000 or can be made from local mud, wattle, etc. for about \$7.

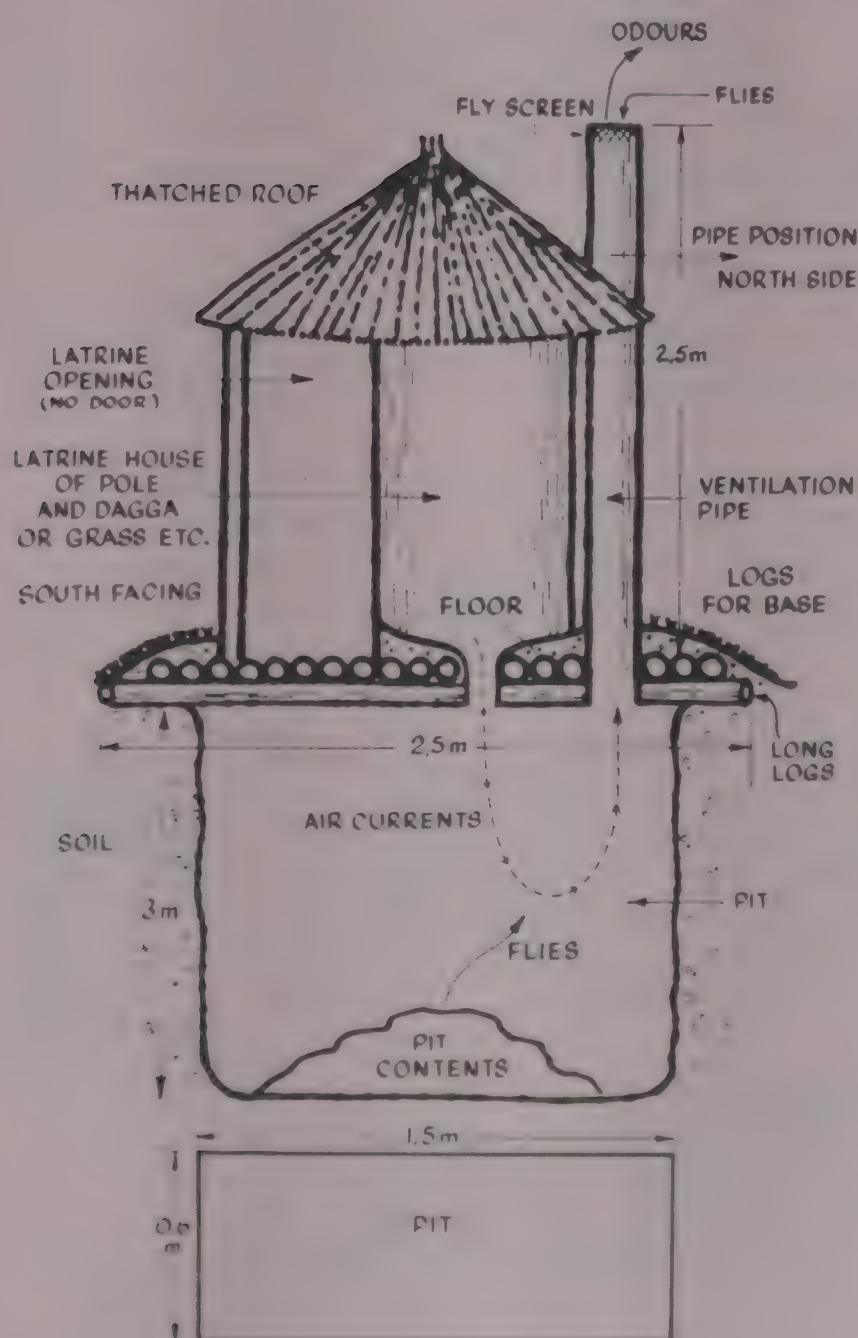


Fig. 6.40: The ventilated improved pit (VIP) Latrine.

Wright, A.M. (1977) Rural latrines, Ghana. Report on International Technical Advisory Group Meeting. Contains useful diagrams and a ranking of systems, using a rating and scoring method.

* Zaire, Centre d'éducation sanitaire de Kangu-Mayombe (1973) Education sanitaire. Fr. Summarised In Contact No. 9, November 1973.

GRAPHIQUE D'EDUCATION
SANITAIRE



Fig.6.41: Zaire: Extracts from a series on hookworm.

6.5.

Housing improvement

* **Cooperative Housing Foundation** (1981) Housing and health: An analysis for use in the planning, design and evaluation of low income housing programmes.

* **Thailand, Ministry of Health** (1981) Community health volunteers' nutrition and health work manuals.

p. 64: Pictures of a sanitary house and an insanitary house.

"Residents of a clean house are comfortable in body and mind and are less susceptible to illness."

Three ways to maintain a clean house are suggested:

1. Domestic animals should not be kept underneath the house. If this is impractical, then the manure should be collected daily.
2. In the main house, windows should be well distributed to ensure fresh air circulation.
3. The area round the home should be kept clean by regular sweeping.

VITA (1978) Village technology handbook.

Describes the construction of houses, home improvement and communications, etc.

6.6.

Food storage and preservation

See Section 2.2.3.2: Food storage to reduce post harvest loss.

6.7.

Home and restaurant hygiene

* **FAO** (1975) Child care. A handbook for village workers and leaders.

A pictorial book intended for housewives, village leaders and social centres interested in child development and growth.

Includes chapters on: a healthy mother; a clean home; growing up. There are activities for follow up and review at the end of each chapter.

* **FAO** (?1980) Rural home techniques: Labour saving ideas, Vol.6. Series 3. Eng. Fr. Sp.

Instructional leaflets for making:

Dishwashing table - No.1; Fly trap - No.5; Food covers - Nos.11 and 12; Food shelf - No.13; Utensil rack - No.14; Furniture from crates - No.15; Shelves from crates - No.16; Fireless cooker - No.8.

Jamaica, University of the West Indies, Dept. of Social and Preventive Medicine (?1982) Manual for community health workers. "Increasingly Jamaicans eat in restaurants and the community health worker needs to be aware of possible public health problems in such public eating places."

Jamieson, S. (no date) A first hygiene book for village schools in tropical regions. Vanuatu.

This is a series of pictures with some text explaining the importance of: clean water for drinking, a clean house, clean

food, oral hygiene, clothing, the prevention of sickness, etc. The drawings are very good and could stand by themselves without the text.

Kehrberg, N. (ed) (1975) Ways to better health. (Primary/upper elementary health education lesson plans). 29 pp.

These are 22 lessons on personal hygiene, water and sanitation, communicable diseases and nutrition. They are fully illustrated, and include the objective, target and the time a lesson should take. A typical example is as follows:

Lesson (18)	- Measles
Age	- Upper elementary
Time	- 20 minutes
Objective	- To instruct students about the common disease "measles" and that food is necessary for a child with measles.

This is followed by questions such as: How many of you have had measles? What food/treatment is given for it? The lesson is completed by a brief examination on measles and a 'homework' to inform parents what the student has learnt at school.

* Mozambique, Ministry of Health (1977) Textos de educacao sanitaria; O minimo higienico das aldeias comunais; Relacao dos medicamentos e artigos a penso a serem utilizados por technicos e agentes de medicina. Port.

Very useful.

Ross Institute (1979) The housefly and its control. Bulletin No. 5. Revised edition.

Saiuzmultifilm, Moscow (1973) Health begins at home. 10 mins. Animated cartoons, colour.

The spirit of sickness, having caused much trouble and suffering all over the world, decides to concentrate her attention on a little house where a family is living happily and healthily. After much effort the spirit manages to install herself but with the help of the medical services the family finally evacuates the evil spirit and returns to its normal life. The spirit of sickness will not admit defeat and searches every corner of the earth to try and find other homes where she might penetrate and spread diseases and misery; but even in distant lands the health services are busy protecting the people. (Annotation from WHO).

US, Montana State Board of Health (?1979s) Be your own restaurant inspector.

US, Ohio State Medical Association, Committee on Rural Health (?1970) Health Councils.

6.8.

Prevention of child accidents at home

See Section 8 of this bibliography.

Promoting rural development

* de Veen (1980) The rural access road programme.

The rural access road programme (RRP) is a road construction project which represents the first attempt in Africa to implement labour-based methods efficiently on a large scale. The book is divided into sections on administrative, organisational and training systems.

FAO (1979) Training for agriculture and rural development.
Eng. Fr.

* India, Rural Unit for Health and Social Affairs (RUSHA)
(1981) Village veterinary guide. Mimeo.

USAID, Bureau for Program Coordination (1980) The socio-economic context of fuelwood use in small rural communities. AID evaluation special study No.1. 292pp.

This report is included because of the scarcity of materials on the subject. It covers access, production, harvest, collection, transportation, distribution and consumption of firewood and charcoal in rural communities and in community fuelwood programmes. It is intended for those seeking information about the socioeconomic context of community fuelwood, and guidance in resolving key issues encountered in community fuelwood programmes.

Werner, D. (1977) Where there is no doctor.

"When you try out a new idea, always start small. If you start small and the experiment fails, or something has to be done differently, you will not lose much. If it works, people will see that it works and can begin to apply it in a bigger way.

Do not be discouraged if an experiment does not work. Perhaps you can try again with certain changes. You can learn as much from your failures as your successes. But start small. Here is an example of experimenting with a new idea.

You learn that a certain kind of bean, such as soya, is an excellent body-building food. But will it grow in your area? And if it grows, will people eat it?

Start by planting a small patch - or 2 or 3 small patches in different conditions of soil or water. If the beans do well, try preparing them in different ways, and see if people will eat them. If so, try planting more beans in the conditions where you found they grew best. But try out still other conditions in more small patches to see if you can get an even better crop.

There may be several conditions you want to try changing. For example: type of soil, addition to fertiliser, amount of water, or different varieties of seed. To best understand what helps and what does not, be sure to change only one condition at a time and keep all the rest the same."

Reduction of pollution

Canada, Red Cross Society (1978) Pollution is well are you?

A Red Cross Youth Environmental studies programme.

de Glanville, H., Schilling, R.S.F. and Wood, C.H. (eds.) (1979 reprinted 1983) Occupational health.

Chapter 12: Occupational health risks.

The various agents which give rise to occupational ill health are discussed. They include: (1) chemical agents (lead, mercury, asbestos, radioactive ore, oil, manmade plastics, fibres, fertilisers); (2) physical agents (noise, heat, cold, radiation); (3) mechanical agents (tools for drilling holes, picks, hammers, shovels) which can cause "acid hands", cramps etc.; (4) infective agents (anthrax, brucellosis); (5) psychological agents (e.g. stress arising from migration from rural to urban areas). The improvement of hazardous work environments into safer, less dangerous processes is described.

* Fletcher, T. (1975) Noise; fighting the most widespread industrial disease.

"Noise is the most underestimated health hazard that the working population is exposed to". Noise is not just an irritation: it is a hazard to health.

World Bank (1978) Environmental considerations for the industrial development sector. 128pp.

Includes sources and effects of industrial pollution of the air, water and land, and criteria and standards for monitoring pollution. It also describes sampling and analytical procedures, treatment technology, economic aspects, and sociological, planning and political aspects.

6.11.

Health promotion through a healthy lifestyle and personal habits

Health Education Council, UK (1979) Looking after yourself. A very useful booklet for the general public.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals. Emphasises personal hygiene: p.62.

US, Dept. of Health, Education and Welfare (no date) Living well: An introduction to health promotion and disease prevention. An illustrated booklet addressed to the US public, but which could be useful to other countries. Includes: reducing the risks to good health (smoking, accidents, abuse and misuse of alcohol); the role of life style (lack of exercise, habits, unsafe driving, stress etc.); and healthy practices (adequate nutrition, child stimulation, careful driving etc.).

6.12.

Appropriate technology - general source books

* Darrow, K., Keller, K. and Pam, R. (1981) Appropriate technology source book. Volumes I and II.


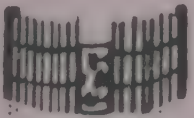

An annotated bibliography, intended as a guide to practical books and plans for village and small community technology.

* Lutheran World Service (1977) Village technology handbook. A booklet providing the sources, and outlines of the content, of many types of useful information.

6.13.

Planning, organisation and evaluation of environmental health services

- * APHA (American Public Health Association) (1982) Environmental sanitation and integrated health delivery programmes. Monograph Series No.4. Includes evaluating environmental health needs, setting priorities, programme planning, implementation, evaluation.
- * Cairncross, S. et al (1980) Evaluation for village water supply planning.
- * Earthscan (?1982) Water, sanitation, health for all?
- * Indonesia (1983) Monitoring environmental health. Vibro. (March) No.XXXV.

Activity	Visit						
	1	2	3	4	5	6	..12
 Clean home	x	0	0	0	0	0	
 Keened yard	x	x	(x)	0	0	0	
 Yard planted	x	x	x	x	0	0	

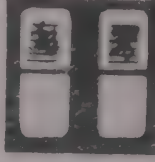

Activity	Visit						
	1	2	3	4	5	6	..12
 Windows used jenucia	x	0	0	0	0	0	
 Pens for livestock	x	x	x	0	0	0	
 Smoke funnel in Kitchen	x	x	x	x	x	x	

Fig. 6.42: The Garung monitoring form.

- * IDRC (1978) Low cost technology options for health manpower and sanitation - annotated bibliography and review. IDRC-102e. More than 6000 articles and entries are reviewed or annotated.

* Mozambique, Ministry of Health (1977) O minimo higienico das aldeis comunais. Port.

A small booklet with no illustrations, but full of very useful information.

Pisharoti, K.H. (1975) Guide to the integration of health education in environmental health programmes. WHO Offest Pub. No.20. 81pp.

* Schulzberg, G. (1983) Minimum evaluation procedures for water supply and sanitation projects. Document No.ETS/83.1. CDD/OPR/83.1.

* Scotney, N. (1976) Health education; a manual for medical assistants and other rural health workers. 141pp.

A short clear description of the problem of obtaining clean water from wells and a five-step method of approaching it, which is also applicable to many other situations: pp.15-21.

* White, Alastair and Gordon, G.M. (In press) Guidelines for training community motivators for water supplies and sanitation.

* World Bank (1982) Appropriate technology for water supply and sanitation, sanitation alternatives for low income communities, a brief introduction.

A useful non-technical book which includes sanitation programme planning, sanitation technologies and technology selection.

6.14.

Keeping up to date with new ideas on environmental health, appropriate technology and community development

For water newsletters see Section 6.1.1.4.

* CEPIS Newsletter Sp. Casilla Postal 4337, Lima 100, Peru.

Decade Watch (quarterly) UNDP Division of Information, One UN Plaza, New York, NY 10017 USA. Eng.

Brief, non-technical information on clean water and sanitation. The 1st issue appeared in June/August 1982.

Ecodevelopment News. Eng. Fr. 54, Boulevard Raspail, Room 309, 75270 Paris. Cedex 06, France.

Some useful articles but the newsletter is tightly typewritten.

* International Drinking Water Supply and Sanitation Decade Newsletter (?monthly) UNDP, Division of Information, One UN Plaza, New York, NY 10017 USA. Eng.

Special issues have dealt with subjects like: the prevention of guinea worm disease; the internal financing of water supply; and sanitation in developing countries.

* IRC Newsletter (?monthly) Information support to the international drinking water supply and sanitation decade. International Reference Centre for Community Water Supply and Sanitation. PO Box 5500, 2280 HM Rijswijk, The Netherlands. Eng. Fr.

A briefing on new publications, new techniques etc.

Suara Sam (bimonthly) Sahabat Alam (Malaysia's Friends of the Earth) (SAM) Penang, Malaysia.
Vol.1. No.1. (1982) covered river pollution, pesticides and news of environmental action.

* Water Log (first issues July and December 1981) Earthscan, 10 Percy St., London W1, UK.

Covers waste and sanitation. It is intended for journalists, editors and others. It is funded by SIDA and the Netherlands Foreign Ministry.

* Waterlines (quarterly) 'The journal of appropriate water supply and sanitation technologies'. Intermediate Technology Publications Ltd, 9 King Street, Covent Garden, London WC2E 8HN, UK. Eng. Sp. edition planned.

Aimed at communities, field workers, volunteers and project organisers. The first issue (July 1982) carried stories on bamboo-cement, water tanks, appropriate latrines and other related topics. The second issue (October 1982) carried a very useful article on women as the key to success of new water supplies and reported on latrine taboos from many countries.

* WHO (occasional) Appropriate Technology for Health Newsletter. WHO 1211 Geneva 27, Switzerland. Eng. Fr. Sp. Arabic.

An excellent newsletter which often focuses on specific topics e.g. Solar energy: Issue No.11; Health education methods and materials in primary health care: Issue No.10.

Notes

Notes

7. Care of the sick child.



7. Care of the sick child.

7.1. General sources on care of the sick child

Many books cover a number of childhood illnesses and problems. In this section a few sources have been drawn upon for each condition. There may be further information in the books listed below.

* Balldin, B., Hart, R., Huenges, R. and Versluys, Z. (1981) Child health; a manual for medical assistants and other rural health workers.

* Biddulph, J. (1976) Child health for health extension officers and nurses in Papua New Guinea.
A comprehensive and easy to use manual full of line illustrations and large writing.

Bomgaars, M. and Bajracharya, B. (1974) Symptom-treatment manual. 42pp.

* Colgate, S.H. et al (1979) The nurse and community health in Africa.
Chapter 5, Section V: Treating sick children.

* Dean, P. (1975) Paediatric out patients manual, Africa.
A small practical booklet which is easy to handle and to use. Adopts a symptom approach to ill health in children: fever, cough, diarrhoea, rashes, etc., and their management with fluids, vaccination, etc., and the improvement of hygiene.

* de Hertaing, R. and Courtejoie, J. (?1977) L'enfant et la sante.

* Ebrahim, G.J. (1978) A handbook of tropical paediatrics.
Includes the assessment of growth; motor, mental and social development; nutrition; common emergencies; care of the newborn; infectious diseases; drug dosages.

* Ebrahim, G.J. (1980) Practical mother and child health in developing countries.
Includes antenatal care; delivery; care of the newborn; resuscitation of the newborn; low birth weight; breastfeeding; weaning; young child clinics; immunisation; feeding; day care centres; problems of urbanisation; community development and maternal and child health; planning families.

* Essex, B.J. (1975) Diagnostic pathways in clinical medicine.
Guidelines for treatment are not included. May be useful for senior or experienced workers.

Fountain, D.E. and Johnson, R. (no date) Infirmier, comment faire votre diagnostic. Fr. Eng.

* Graves Medical Audio-visual Library Audiotape slide programmes on paediatrics.

- India, Coordinating Agency for Health Planning (1973) Workshop on health care of children under five. 98pp.
Includes: Why have an under-fives clinic?; Organisation of under-fives clinics; the road to health chart; nutrition and the under-fives; infectious diseases and immunisation; family welfare planning; community involvement; evaluation and research.
- Kenya Red Cross Society (1974) Simple mother and baby care. Swahili, Eng.
Useful reference material.
- * King, M. (1978) Primary child care, a manual for health workers. Book 1.
Comprehensive reference material which is useful for senior workers. Includes: disease in children; supplies and equipment; caring for a healthy child; caring for a sick child; records and reports, malnutrition; cough; diarrhoea; fever; skin disease.
- Madang Paramedical Training College (1974) Pocket book of drug dosages and procedures for health extension officers.
- * Management Sciences for Health (1974) Problem action guidelines for basic health care; a tool for extending effective services through auxiliary health workers.
- Mennesson, S. (no date) Meres et enfants d'Afrique. Fr.
- * Morley, D.C. (1973) Paediatric priorities in the developing world.
- Mozambique, Ministry of Health (1977) Formulario Nacional de Medicamentos. Also Relacao dos medicamentos e artigos de penso a serem utilizados por technocos e agentes de medicina. Port.
- Mtulia. I.A.T. (1976) Pharmacology and therapeutics. Practical pharmacology. What, how, where and how much drugs are used. The toxic effects, dosage and administration of drugs are well explained.
- * Olatunde, A (1979) Self medication, benefits, precautions and dangers.
See especially Chapter 5: Problems with self medication in children.
- * Papua New Guinea, Ministry of Public Health (1979) Standard treatments for common illnesses of children in Papua New Guinea. A manual for nurses, health extension officers and doctors. 2nd edition. 66pp.
This book is more than a national formulary. It includes symptoms for diagnosis and the locally acceptable choice of drug.
- Tanzania, Mwanza Programme (1970) Standard notes for Tanzanian dispensaries.
- * Uberoi, I.S. et al. (1974) Child health care in rural areas. A manual for auxilliary nurse midwives. 364pp.
A useful low cost reference text; comprehensive, but easy to use.

It includes the training of auxiliary nurses, the prevention of disease, immunisation, assessing the health of children, care of the newborn, giving drugs and treatment.

WHO (1980) The primary health worker; working guide; guidelines for training; guidelines for adaptation.

* Wyatt, G.B. and Wyatt, J.L. (1973) Medical assistants' manual; a guide to diagnosis and treatment.

A comprehensive, well illustrated book on common illnesses, mostly from the third world. The last section - the symptom index gives an easy approach to diagnosis for the medical assistant.

7.2

Planning, organisation and evaluation of care of the sick child

There is some material in many books. The list below contains some useful ideas but is not comprehensive.

* Afganistan, Ministry of Public Health (1977) Basic health centre manual.

Includes flow charts for use in a health centre, as guidelines for treatment.

* Asian Community Health Action Network (ACHAN) (1982) Drugs in Bangladesh. Link 2 (3) Special issue.
Raises important national policy issues.

King, M., King, F., and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1.
Teaching sick child care with the use of case studies.

Maniciaux, M. (1981) Children of disadvantaged families. Children of the "Fourth World", i.e. children of large families or neglected areas, who are frequently ill.

Maneno, J., Schluter, P., Sjoedsma, A.C., Vogel, L.C. and Savage-King, F. (1982) Guidelines for the management of hospital outpatient services.
Covers nine management steps. Includes 1) S.O.S. Short of Staff; 2) S.O.S. Short of Space; 3) O.O.S. Out of Stock; 4) Human problems; 5) The manager and the outpatient department team; 6) prescribing, preparing and dispensing drugs.

Morley, D.C. (1972) Management in Child health.
24 slides, with explanatory text. Cassette tape is also available. In this set of slides the ideas are addressed to health workers in any part of the world. The doctor-patient relationship should not be one of writing prescriptions: "bus ticket" or "cafeteria". Instead a more amicable and caring approach is needed. Learning in a prestigious multi-million dollar teaching hospital is diametrically different from learning in the community. The former divorces the student from his community, the latter creates ties and bonds. One of the major tasks of a manager is in maintaining a balance between needs in a continually changing environment, getting the priorities right, a balance between outpatient care and inpatient care, between

curative and preventive care etc. Other issues, such as the brain drain - emigration of the elite from developing to developed countries are also mentioned.

Morley, D.C. (1973) Paediatric priorities in the developing world.

* Morley, D.C. and Woodland, M. (1979) See how they grow.

Prior, E.N. (1976) A manual of anaesthesia for the small hospital.

* Rohde, J.E. and Sadjimin, T. (1980) Elementary school pupils as health educators, role of school health programmes in primary health care. Lancet 1 (8182): pp.1350-1352.

* Werner, D (1977) Where there is no doctor. Chapter 4: pp.18-19. Different kinds of sickness (infectious and non-infectious) and their causes. How to take care of a sick person and home management of the sick child.
"Questions and answers on some folk beliefs and home remedies: These examples are from the mountains of Mexico, the area that I know best. Perhaps some of the beliefs of your people are similar. Think about ways to learn which beliefs in your area lead to better health and which do not.

When people think someone is bewitched, is it true that he will get well if his relatives harm or kill the witch?



FALSE! No one is ever helped by harming someone else.

Is it true that when the 'soft spot' on top of a baby's head sinks inwards, this means the baby will die of diarrhoea unless he gets special treatment?



This is often true. The 'soft spot' sinks because the baby has lost too much liquid (see p.151). Unless he gets more liquid soon, he may die (see p.152).

Is it true that if the light of the eclipsing moon falls on a pregnant mother, her child will be born deformed or retarded?



This is not true! But children may be born retarded, deaf or deformed if the mother does not use iodised salt, or for other reasons (see p.318).

Is it true that mothers should give birth in a darkened room?



It is true that soft light is easier on the eyes of both the mother and the newborn child. But there should be enough light for the midwife to see what she is doing".

Fig. 7.1.

Wood, C.H. (1977) Improved patient management in primary health care: the development of the flowchart approach for use by health workers. 10pp. Eng.

7.3.

Care of the child with diarrhoea

Care of the sick child with diarrhoea inevitably needs to lead to diarrhoea prevention by promotion of mother and child health and improvement of sanitation. Sometimes it also requires epidemic control. The list following does not separate these four components. For a detailed subdivision see WHO (1982) Diarrhoeal disease control, examples of health education materials. WHO/CDD/1982. See also Section 6 of this bibliography on environmental health.

* Aarons, A., Hawes, H., and Gavton, J. (1979) CHILD-to-child. A book.

Chapter 6: Care of the child with diarrhoea.

This is written for teachers, health workers and youth leaders so that they can introduce the 'idea' to children, using illustrated examples of what dehydration due to diarrhoea means: "A child who is dehydrated is like a plant without water." There are games to play (the gourd game, the tin game), and the preparation of water, salt and sugar into a drink is shown. Finally, evaluation procedures are suggested.

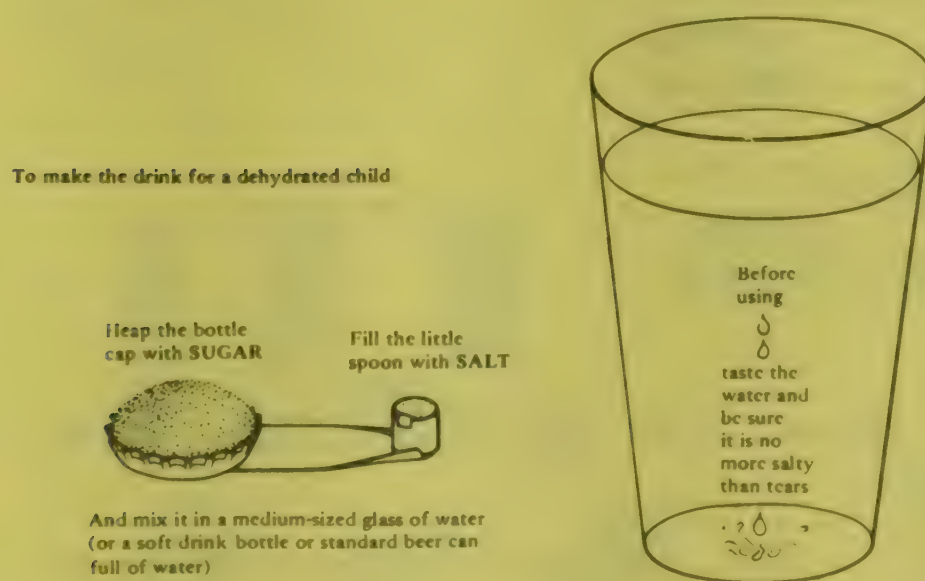


Fig. 7.2: Aarons, A. et al. (1979) CHILD-to-child: p.61.

Children can make a measuring spoon for the special drink using local materials. Here is one idea:

A spoon for making salt and sugar water for treating diarrhoea

There are many things you can do to make spoons to measure the right amount of sugar and salt.

Here is one idea:
(be sure to make the spoons the right size)

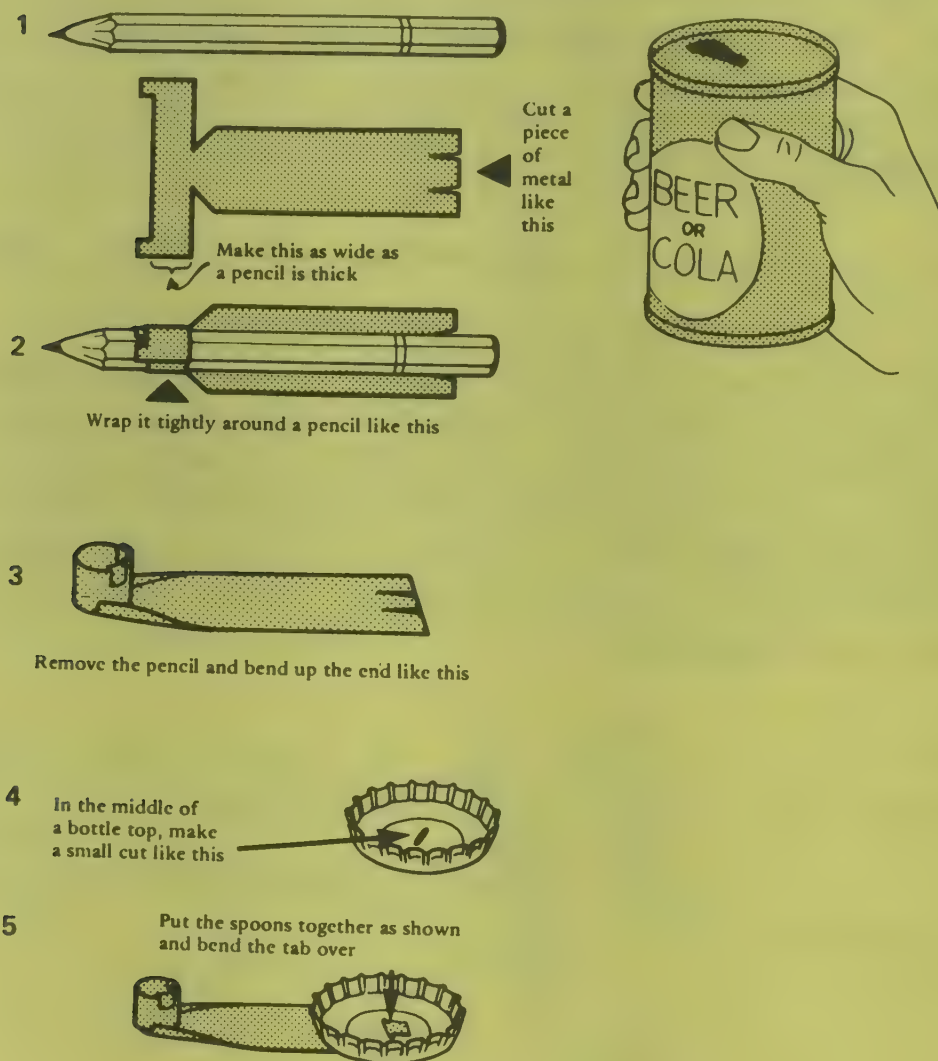


Fig. 7.3: Aarons, A. et al. (1979) CHILD-to-child: p.60.

Barnabas, G. (1982) Treatment of diarrhoea by oral rehydration. Tigrinya.

A booklet produced for the Eritrean Relief Association, which is active in Eritrean rural areas and amongst Eritrean refugees in Eastern Sudan.

* **CHILD-to-child Programme** (1979) Activity sheets: Care of children with diarrhoea. Eng. Fr. Sp. Port. Arabic. Shows how to care for children with dehydration. Includes many line diagrams.

* **Cutting, W.A.M. et al** (1981) Diarrhoea management. 24 slides with text. A cassette tape is also available. Includes current knowledge of diarrhoea management and treatment, e.g. breastfeeding a child with diarrhoea is encouraged. Slides are arranged into 8 groups and deal with: the problem of diarrhoea (2 slides); recognising dehydration (3 slides); difficulties in

intravenous rehydration (3 slides); how oral rehydration works (3 slides); how to give oral fluids (4 slides); home made oral fluids; and how much to give (3 slides); oral rehydration and food (3 slides). Drawings and teacher's notes are given in the 17pp. text accompanying the slides.

* **Diarrhoea Dialogue** (quarterly) Eng. Fr. Sp. Port. Arabic in future.

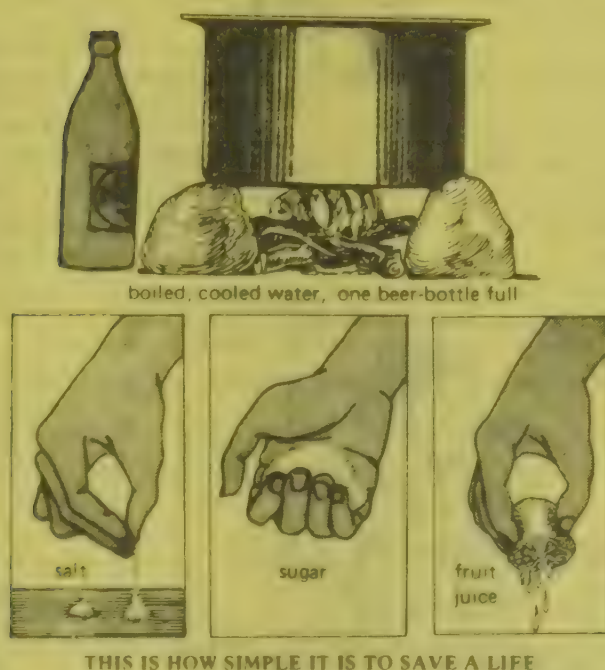
A quarterly newsletter distributed free. Covers all the recent trials of diarrhoea management - particularly oral rehydration. Very useful for keeping up to date.

Egypt, Ministry of Health Rural Health Department (1982)

Egypt: Mothers cut diarrhoeal deaths in half with homemade treatment. Reported In Salubritas Health Information Exchange 6 (1) January 1982.

Reports a study of 4 ways to educate the public to use oral rehydration solution; distribution of packages of solution by nurses when visiting homes; retail selling of the packets; instruction to mothers on how to make the preparation at home using local ingredients; and instruction to mothers on using 50% when mothers made fluid from household salt and sugar, 40% when home distribution of oralyte was used, 15% with use of the commercial packages, and 12% in the control group.

* **Eshuis, J. and Monschot, P. (1978) Communicable diseases.** pp.122-123: recommends a finger pinch of salt, a handful of sugar, and some fruit juice added to a beer bottle of water: "this is how simple it is to save a life".



Preparation of home-made oral rehydration solutions*

One pint of boiled water (1 beer-bottle full), two thumb-and-two-finger pinches of salt, one four-finger handful of sugar and some fruit juice.

Give every child as much as possible of this rehydration mixture. Continue even when children are vomiting.

In severe dehydration parenteral rehydration is necessary.

Fig. 7.4.

Prevention Prevention depends on breaking through the faeco-oral transmission cycle.

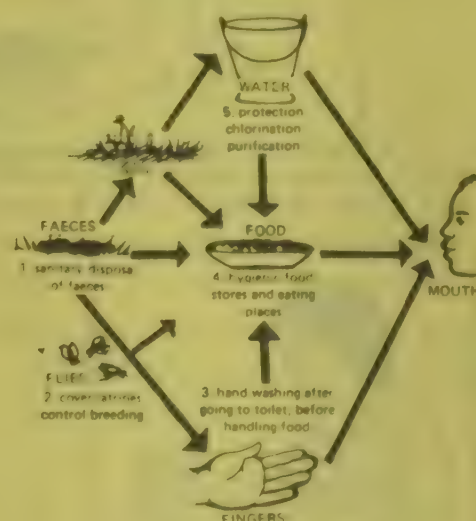


Fig. 7.5.

* Glimpse. Newsletter of the International Centre for Diarrhoeal Disease Research, Bangladesh.

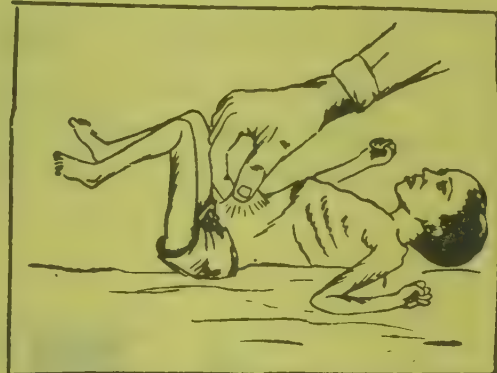
* Gordon, G. and Gordon S. (1981) Nutrition and child health flannelgraphs: Diarrhoea - prevention and home management. "Diarrhoea - prevention and home management is part of a series of flannelgraphs", for Savannah areas of Africa. This script concentrates on the following subjects: how to recognise diarrhoea; where people get diarrhoea from (faeces, stools); how diarrhoeal germs are transmitted (from faeces to mouth); the importance of clean water and improving the water supply. It also discusses: the dangers of dehydration, making oral rehydration mixture, feeding children during diarrhoeal sickness. There are useful pictures throughout the text, which is written in simple English.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Treatment of diarrhoea, Prevention of diarrhoea. Leaflets. Several languages. Well illustrated leaflets.

Treatment of Diarrhoea (दस्तों का इलाज)



Diarrhoea is Passage of watery stools more than 3 times per day
दस्तों की बिमारी में दिन में 3 बार से ज्यादा पतली टट्टी आती हैं



If diarrhoea is not treated early, dehydration occurs due to excessive loss of water and salts. This can be serious.
अगर इलाज न किया जाय तो दस्तों की बिमारी में पानी और नमक की कमी हो जातो है और यह खतरनाक भी हो सकती है



Dehydration can be prevented by oral rehydration solution. This consists of glucose 10 g, salt 1.75 g, sodium bicarbonate 1.25 and potassium chloride 0.75 g. This mixture should be dissolved in half liter of clean water (3 cups).
पानी और नमक की कमी जलबन्धन को रोकने के लिए



Oral rehydration solution should be tasted before giving it to the patient.



To prevent complications give oral rehydration solution every 2-3 minutes by a spoon. Do not give it by a bottle.
जलबन्धन से रोकने के लिए



For best result continue to breast feed the baby in between rehydration solution. This provides nutrition and prevents complications

रोहाड़ेसद सलूशन के इलाज के बीच में माँ का दूध बन्द न कीजिये। माँ का दूध पिलाने से बच्चों को कोई खतरा नहीं रहता और उसकी ताकत बनी रहती है।



Continue to feed the child easily digestible foods like Banana Dalia, Rice, Dal, and curd during diarrhoea. This prevents malnutrition

दस्तों की बिमारी के दौरान बच्चे को आसानी से पचने वाली चीजें जैसे केला, दलिया, दाल, चावल, दही देनी चाहिये। ऐसा करने से बच्चे को सोखे की बिमारी नहीं होती।



Simple treatment of diarrhoea outlined above restores child's health quickly and prevents complications.

उपर लिखो इलाज के करने से बच्चा जल्दी ठीक हो जाता है और खतरे से बचा रहता है।

April 1981

Department of Community Medicine PGI Chandigarh

Fig. 7.6.

Indonesia, Ministry of Health (1980) Buku pedoman petugas lapangan upgk (Usaha Perbaikan Gizi Keluarga).

pp.46-47: Includes making oral rehydration solution, using oralyte or sugar and salt. The text is well illustrated.

* Jamaica, Ministry of Health (1982) Educational materials for the diarrhoeal diseases control programme in Jamaica. 21 pp. A useful booklet which includes a pretesting questionnaire for two booklets: (1) keeping ourselves and our babies healthy; (2) what to do when your baby has diarrhoea.

* King, M., King, F. and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1. Chapter 9: Diarrhoea.

After discussing in simple English some forms of diarrhoeal diseases (amoebic, bacillary, giardiasis, malaria) and other infections related to diarrhoea, the authors show how to manage rehydration. The preparation of oral solution and intravenous rehydration are well explained with illustrations.

* King, M., King, F. and Martodipoero, S. (1979) Primary child care. A set of 240 slides and explanatory script. 35pp. A cassette tape is also available.

This set of slides covers most common childhood conditions. Slides Pcc 17-24 and Pcd 1-12 deal with oral rehydration, intravenous rehydration, preparation of oral fluids at home etc.

* Pan American Health Organization (PAHO) (1983) Oral rehydration therapy. An annotated bibliography. 116pp. A bibliography divided into 5 sections: history, clinical traits, composition, impact, implementation.

Philippines, Rural Missionaries (1976) Guide for community

health programs. pp.48, 49: diarrhoea; teaching the subject to auxiliaries.

*** Population Reports (1980)** Oral rehydration therapy (ORT) for childhood diarrhoea. (Eng - 1980/Sp - 1981/Fr - 1981)
This is a review issue on oral rehydration. Authors' summary: "About one of every 10 children born in developing countries dies of diarrhoea before reaching the age of 5. Oral rehydration therapy (ORT) can substantially reduce the heavy toll. ORT means drinking a solution of water, sugar and mineral salts to replace the water and salts lost by the body during diarrhoea. This counteracts dehydration, which is the direct cause of diarrhoeal deaths. Making this simple, inexpensive, and effective treatment available throughout the world is a major public health challenge. The scientific rationale for oral rehydration is firmly established. During diarrhoea the body rapidly loses fluids and the electrolytes sodium, potassium, chloride and bicarbonate, while at the same time the ability of the intestines to absorb fluids and electrolytes, in the form of salts, taken by mouth is impaired. About 10 per cent of diarrhoeal episodes lead to dehydration and, if untreated, one or two per cent become life-threatening. When the body becomes dehydrated, the only effective treatment is rehydration - replacing intravenously or orally, approximately the same volume of water and electrolytes lost."

Description of several teaching manuals from around the world.

*** Rohde, J.E. (1980)** Attitudes and beliefs about diarrhoea: the mother's role. Dialogue. No. 2: pp.4-5.
A list of local beliefs about diarrhoea and its effects, and suggestions for messages which could be given to the mothers to match these beliefs.

Local Belief	Possible Marketing Message
1 Diarrhoea is a cleansing of the body.	Drink to replenish water, the cleansing element of the body.
2 The body dehydrates and loses strength during diarrhoea.	Let the body drink to give strength.
3 Diarrhoea is a normal part of growing up.	It is time to provide a tonic — extra fluid — to strengthen the child's developing body.
4 Diarrhoea is a hot illness.	Respond with a cold drink.
5 Athletes drink extra fluid to replace salt and water lost in sweat.	Diarrhoea also causes loss of body salts and fluid. Let your child regain strength through drinking.
6 Diarrhoea is an old and traditionally known condition of imbalance in life forces.	There are many useful traditional remedies for diarrhoea.
7 Diarrhoea is a disease. It kills by dehydration.	Lives can be saved with the newest remedy — oral rehydration.

Fig. 7.7.

Ross Institute (1975) Inflammatory diseases of the bowel.
Bulletin No.9.

Deals with acute diarrhoeal diseases, cholera, the enteric fevers, bacillary dysentery, amoebic dysentery. In each case, ways in which the diseases spread, the clinical state and the treatment and management procedures are described. Transmission and control of the inflammatory diseases of the bowel are mainly through water and food, and control can only be by better use of safe water, adequate cooking, washing hands, construction of latrines, etc. Examples of such measures are shown in the booklet.

* TCHU (?1980) Chart showing method for preparation of glucose/salt solution; rehydration dosage by weight and age.

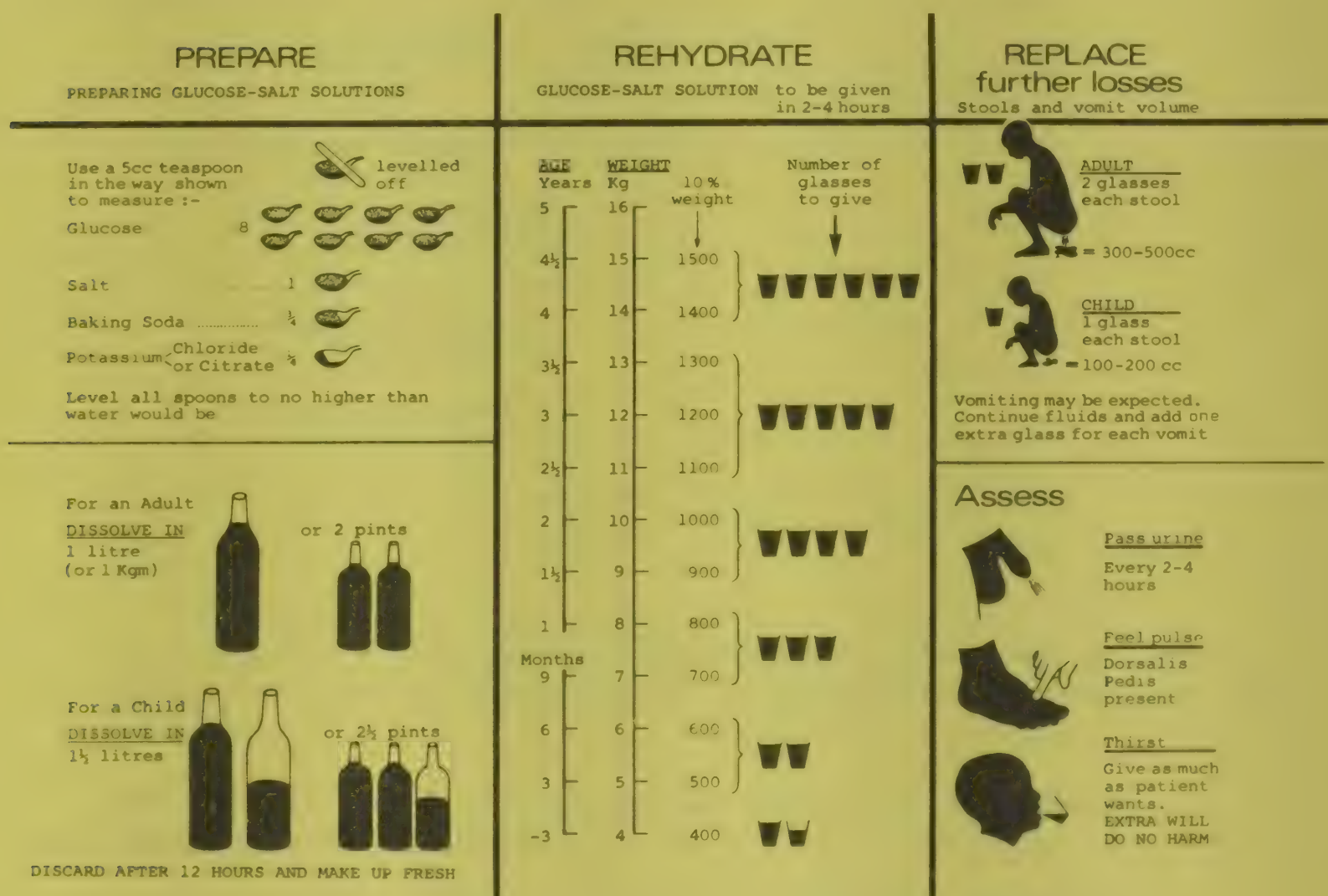
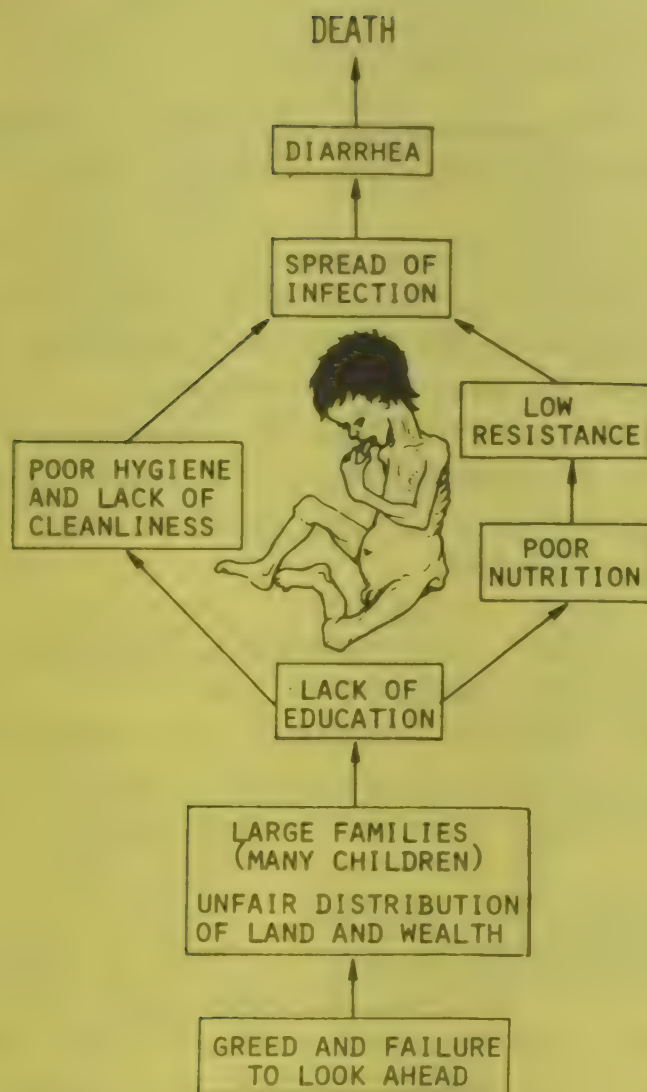


Fig. 7.8.

* TCHU (1977) Rehydration measuring spoon for treating diarrhoea.



The chain of causes leading to death from diarrhea.

Fig. 7.10.

A discussion of the relationship between sunken fontanelles and dehydration and an introduction to rehydration teaching are also included.

WHO (1979) Child care practices related to diarrhoeal diseases. WHO/CDD/79.4.

* WHO (1983) Diarrhoeal diseases control. Illustrated brochure. Eng/Fr. Eng/Sp. Arabic.

Emphasises that diarrhoea and malnutrition are linked in a vicious circle. Food is very important for the sick child. Many children have a huge appetite when they are getting better: they need to be fed as much as they will eat until they regain their size.

* WHO (1982) Diarrhoeal diseases control, examples of health education materials. WHO/CDD/1982.

These include colour coded photographs of posters, flash cards, leaflets, newsletters and comics, slide sets and other sources of information, with English subtitles. Other languages may also be available. Each type of media is subdivided into subjects: clinical management, maternal and child care, water supply and sanitation, epidemic control.

WHO (1980) Environmental health and diarrhoeal disease prevention. WHO/CDD/80.5.

WHO (1984) Treatment and prevention of acute diarrhoea - guidelines for the trainers of health workers. Eng. Fr. Sp. Arabic.

This book describes in simple terms the importance of preventing dehydration in a child with diarrhoea, and gives instructions for making a rehydration solution, using either packets of oral rehydration salts or locally available materials. Easy to follow charts indicate the signs and symptoms of dehydration and summarise the management of diarrhoea. The importance of good domestic hygiene and appropriate child care practices in preventing diarrhoea is stressed.

WHO/CDD (1984) A manual for the treatment of acute diarrhoea. Eng. Fr. Sp. Arabic. WHO/CDD/SER/80.2. Rev.1.

Written mainly for senior health workers in a hospital setting, this shows when to give oral or intravenous fluids. The bacterial and viral causes of diarrhoea and their management are reviewed.

WHO/CDD (no date) Supervisory skills.

Six modules and an introductory booklet aimed at teaching health workers supervisory skills that can be used not only for supervising the treatment and control of diarrhoea, but also for other health services such as immunisation programmes, or the treatment of acute respiratory infections or malaria.

The modules comprise: Community involvement; Treatment of diarrhoea; Targets; Monitoring performance; Training; Monitoring and evaluating usage. A course director's guide and a facilitator's guide are also available.

* WHO/UNICEF (1983) The management of diarrhoea and use of oral rehydration therapy.

A useful booklet which summarises the scientific basis of oral rehydration therapy.

7.4.

Care of the child with acute respiratory tract infection

* Balldin, B., Hart, R., Huenges, R. and Versluys, Z. (1981) Child health; a manual for medical assistants and other rural health workers.

Chapter 10: Diseases of the respiratory system. There are many conditions that affect the respiratory system. The most familiar are the common cold, tonsillitis (chronic), adenoiditis, cough (acute and chronic), dyspnoea, sinusitis; but the most severe are pneumonia, tuberculosis of the lung, foreign bodies in the respiratory tract, otitis media. The diagnosis and management of all these conditions are explained in detail.

* Eshuis, J. and Monschot, P. (1978) Communicable diseases. Section 10.1: Diseases of the respiratory tract. Includes a table showing a management schedule for infections of the upper respiratory tract and bronchi.

management schedule for infections of upper respiratory tract and bronchi		
symptoms	diagnosis	treatment
fever nil or moderate, watery or slightly purulent nasal discharge, child not sick	common cold	clean nose, maybe multivite tab o.d. to keep mama happy, or chloroquin if malaria cannot be ruled out
as above, in a young baby who does not drink well because of blocked nose	nasal obstruction from common cold	clean nose with wet cotton or similar. Ephedrine 1% nose-drops 1 t.i.d. in each nostril
fever +, purulent discharge, signs of bronchitis but not of pneumonia. Child not very sick. Follow up possible	common cold + bronchitis. (Follow up possible)	chloroquin Mist. exp. stim. may be given, but do not believe it to be much use
as above but living far away, especially if underweight, symptoms severe	severe cold + bronchitis underweight early pneumonia not excluded (follow up impossible)	chloroquin oral penicillin 50 mg/kg/day* or sulfa 100 mg/kg/day in 3 divided doses. Or PPF 50000u + benzathine pen (Penadur LA) 600000u for under fives, 1200000 u for older children
as above, but child a bit dyspnoeic and really sick, although pneumonia cannot be proven in physical examination	suspected pneumonia	pneumonia treatment with PPF 50000u/kg stat, and next day to return for continuation of course (5 days), or PPF + benzathine pen as above, conveniently combined in Penadur AP (see appendix)

*For drug doses in children: see appendix

Fig. 7.11.

- * Kapoor, O.P. (1980) Kapoor's guide for general practice. Part III - Kapoor's miniature medical atlas. Includes excellent pictures with accompanying descriptions - for instance see: fig.1-3, clubbing of the fingers, frequent in chronic bronchitis, bronchiectasis, chronic pulmonary tuberculosis; fig.17 and 18, cyanosis - blue colour of the tongue seen in cases of chronic bronchitis, emphysema, chronic respiratory failure; and also figs.184-188, the colour of sputum (purulent, muco-purulent etc.).
- * King, M., King, F., and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1. Chapter 8: pp.99-110. Emphasises the danger of lower respiratory infections. Counting the respiratory rate is useful: as a general rule, over 40/minute is abnormal, over 60/minute indicates pneumonia. Whooping cough is included in this chapter. Simple methods of management are detailed.
- * Morley, D.C. (1973) Paediatric priorities in the developing world. Chapter 11 of this book has the unique approach of relating respiratory infections to malnutrition (see p.197) and seasonal and age incidence. There is a section on the management of each condition in each age group, e.g. pneumonia in the older child (outpatient) and in children under three years, requiring antibiotics, humidity, tube feeding, oxygen, preferably near to home.
- Robinson, M.J. and Lee, E.L. (1978) Paediatric problems in tropical countries.

Chapters 22, 23 and 24 deal with respiratory tract problems in childhood. Chapter 22: Acute respiratory infections in childhood, covers the common cold, tonsillitis and pharyngitis, otitis media, bronchiolitis, bronchitis pneumonia and their management.

Chapter 23: The child who wheezes, deals with respiratory obstruction and asthma, and their management.

Chapter 24: The child with the persistent cough, relates to chronic problems - such as bronchiectasis, bronchial cysts etc. X-ray photographs are used in each section.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals. Management of cough leaflet. Illustrated.

Care of the child with fever

Desjardins, C. and Desjardins, S. (1977) Helping the rural African mother to care for her child; a handbook of health education for health workers.

Health education material for middle-level health workers teaching mothers on infant care. Covers such topics as measles, malaria (fever), diarrhoea, whooping cough, T.B., worms, etc, with sections on infant feeding and breastfeeding, care during pregnancy. The handbook is a good example of local production, written in simple English, with many illustrations.

Folmer, H.F. and Peter, W. (no date) Meddia international slidebank and booklets on tropical diseases. Eng. Fr. Sp. In co-operation with WHO, and the Liverpool School of Tropical Medicine, the Royal Tropical Institute in Amsterdam has developed audio-visual packages for each of several tropical diseases: a microfiche, 84 slides and a 35 mm filmstrip. The slides cover the epidemiology, pathology, parasitology, diagnosis, treatment and control of these diseases and are accompanied by a short explanatory text. They are intended to supplement rather than replace existing textbooks in the training of various categories of health workers (physicians, intermediate and primary health workers) engaged in the control of tropical diseases.

* **Management Sciences for Health** (1974) Fever. Illustrated flow chart, trial version from: Problem action guidelines for basic health care.

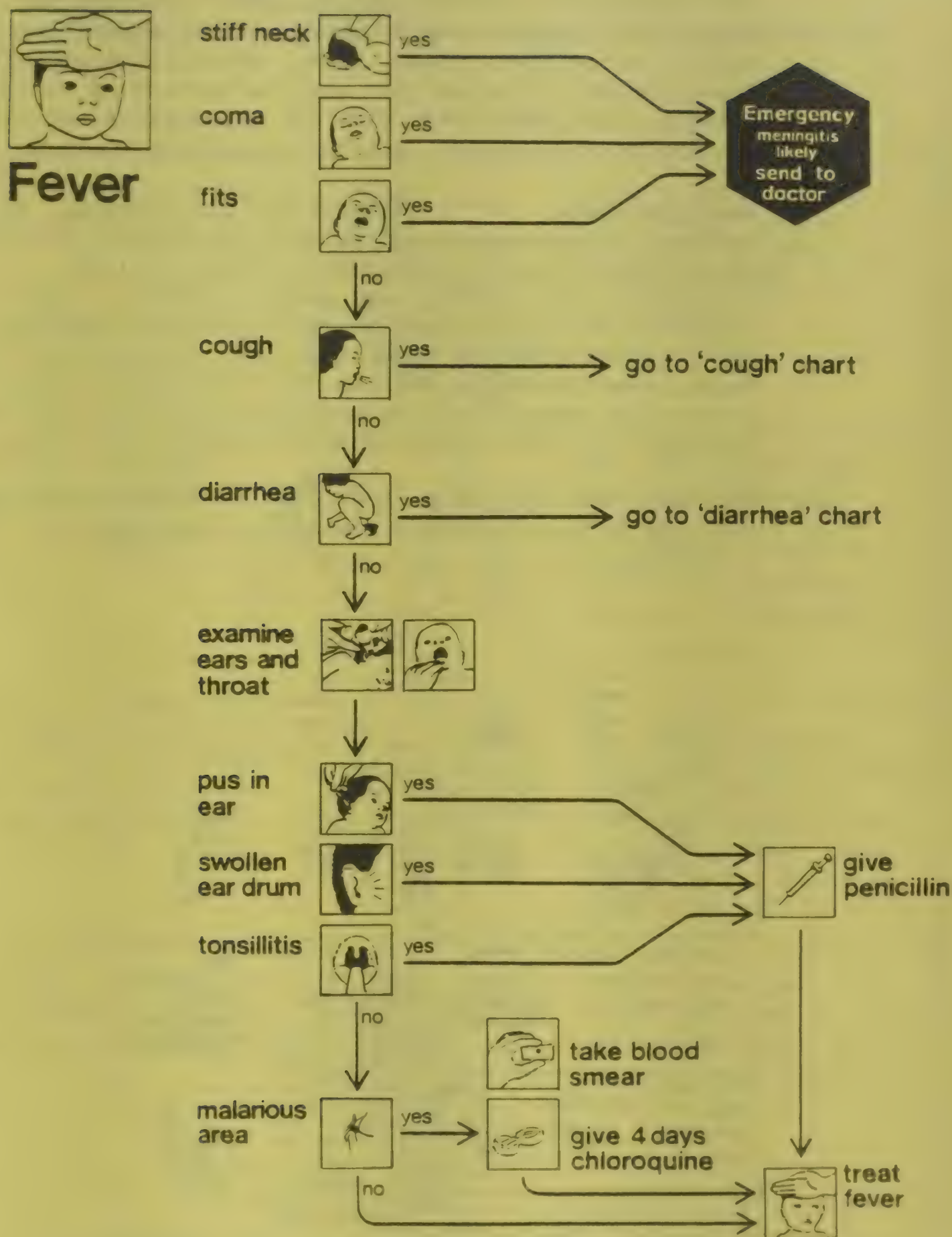


Fig. 7.12.

* Ross Institute (1975) Anti-malarial drugs. Bulletin No.2. Shows how human malaria is spread and lists the anti-malarial drugs available, including their generic and commercial names. Describes the treatment of acute malaria, personal prophylactic drugs, drugs used for mass prophylaxis, drug resistance and drug toxicity. Explains the principles of: why each drug is applied (oral, intravenous); and when it should be applied (prophylactic, treatment).

Ross Institute (1979) Insecticides. Bulletin No.1.

Lists insecticides used not only against mosquitoes but also against houseflies, fleas, mites, ants, termites, ticks etc. The insecticides in current use and the methods of using them (e.g. spraying) are described, with the precautions necessary (e.g. washing with detergent, wearing protective clothes).

Ross Institute (1977) Malaria and its control. Bulletin No.7.

Reviews the epidemiology of malaria throughout the world. The principles of malaria control are then outlined: (1) site selection, i.e. avoiding the areas in which it occurs, (2) treatment of sick persons to avoid further infection, (3) removing the breeding sites of mosquitoes (e.g. burying old tins), (4) using insecticides to shorten the life span of mosquitoes, (5) preventing mosquitoes from biting susceptible (non/semi-immune) persons, (6) taking/administering prophylactic drugs.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals.

P.7: Fever.

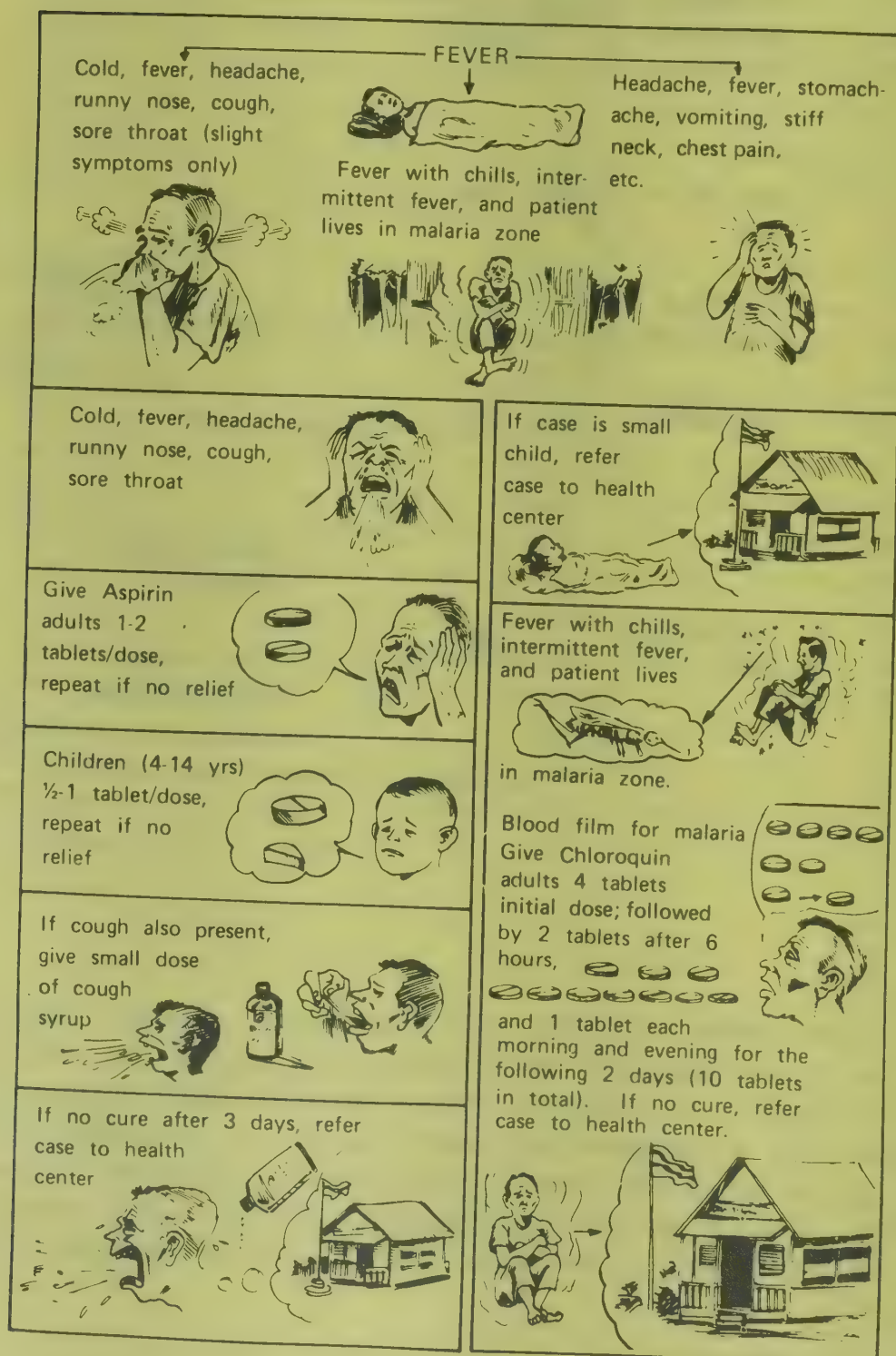


Fig. 7.13

* Werner, D. (1977) Where there is no doctor.
Covers some useful and some less useful traditional methods of dealing with fever.

<p>"Is it a good idea to bathe a sick person, or will it do him harm?"</p>		<p>It is a good idea. Sick people should be bathed in warm water every day.</p>
<p>Is it true that oranges, guavas and other fruits are harmful when one has a cold or a fever?</p>		<p>No! All fruits and juices are helpful when one has a cold or a fever. They do not cause congestion or harm of any kind.</p>
<p>Is it true that when a person has a high fever, he should be wrapped up so that the air will not harm him?</p>		<p>No! When a person has a high fever, take off all covers and clothing. Let the air reach his body. This will help the fever go down (see p.76).</p>
<p>Is it true that tea made from willow bark will help bring fever down and stop pain?</p>		<p>True. It helps. Willow bark has a natural medicine in it, very much like aspirin."</p>

Fig. 7.14.

pp. 26-27: Includes a section on the confusion between different illnesses that cause fever. A typical fever pattern is drawn for malaria, typhoid, typhus, hepatitis, pneumonia, rheumatic fever, brucellosis, and childbirth fever.

"Confusion between different illnessnes that cause fever.

Spanish name: La fiebre (the fever) Name in your area:

Correctly speaking a fever is a body temperature higher than normal. But in Latin America, a number of serious illnesses that cause high temperatures are all called la fiebre - or 'the fever'.

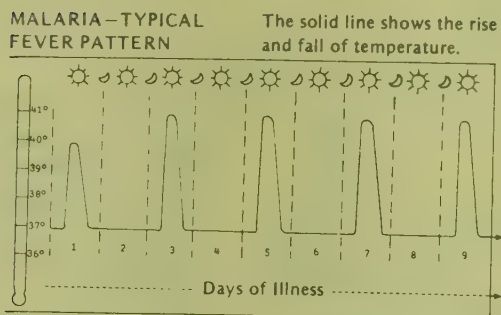


To prevent or treat these diseases successfully, it is important to know how to tell one from another.

Here are some of the important acute illnesses in which fever is an outstanding sign. The drawings show the fever pattern (rise and fall of temperature) that is typical for each disease....."

Malaria: (see p.186)

Begins suddenly with rising temperature and chills. The fever lasts a few hours. Sweating begins as the temperature drops. Attacks usually strike every second or third day. Between fevers the sick person seems fairly well.

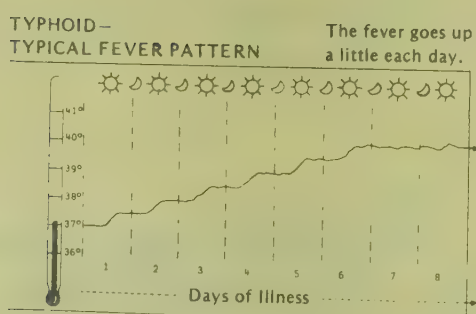


Typhoid (see p.189)

Begins like a cold. The temperature goes up a little more each day. The pulse is relatively slow. Sometimes there are diarrhoea and dehydration, trembling or delirium (the patient's mind wanders). The person is very ill.

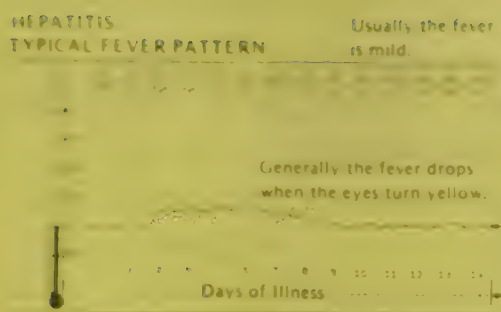
Typhus: (see p.190)

Similar to typhoid. The rash is similar to that of measles, with tiny bruises.



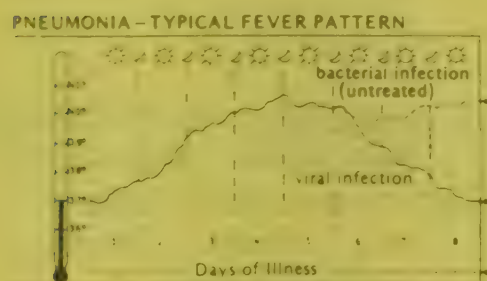
Hepatitis: (see p.172)

The patient loses his appetite, does not wish to eat or smoke. He wants to vomit (nausea). The eyes and skin turn yellow, urine orange or brown, stools whitish. Sometimes the liver becomes large, tender. There is mild fever. The person is very weak.



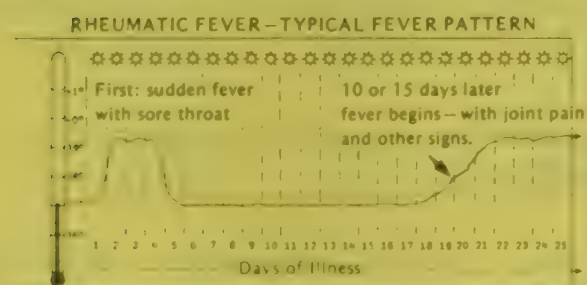
Pneumonia: (see p.171)

Rapid shallow breathing. The temperature rises quickly. There is a chest cough with green, yellow or bloody mucus. There may be pain. The person is very ill.



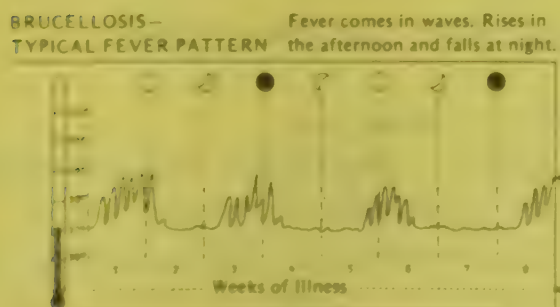
Rheumatic fever: (see p.310)

Most common in children and teenagers characterised by pain in the joints and high fever. This often comes after a sore throat. There may be pain in the chest, with shortness of breath, or uncontrolled movements of the arms and legs.



Brucellosis (undulant fever, Malta fever): (see p.188)

Begins slowly with tiredness, headache, and pains in the bones. Fever and sweating are most common at night. The fever disappears for a few days only to come back again. This may go on for months or years.



Childbirth fever: (see p.276)

Begins a day or more after giving birth. Starts with a slight fever, which often rises later. There is a foul-smelling vaginal discharge, pain and sometimes bleeding.

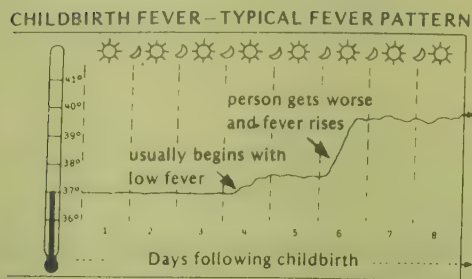


Fig. 7.15

All of these illnesses can be dangerous. In addition to those shown here, there are many other diseases (especially in tropical countries) that may cause similar signs and fevers. These illnesses are not always easy to tell apart. Most are serious or dangerous. When possible - seek medical help."

WHO (1978) Manual for processing and examination of blood slides in malaria eradication programmes. WHO/PA/262.61 Eng. Fr. This manual is intended for the training and retraining of the microscopists dealing with blood examination for malaria parasites, at different levels in malaria control programmes. This manual is not intended to supplant the existing basic books dealing with the techniques of the microscopical diagnosis of malaria, but to guide the less experienced microscopist in the use of methods which give the best results in practice.

7.6.

Care of the child with measles

* Gordon, G. and Gordon, S. (1981) Measles: part of a flannelgraph series entitled: Nutrition and child health. The aims include teaching mothers: how to recognise the signs and symptoms of measles; and how to care for a child with measles to reduce the risk of blindness, malnutrition, dehydration, convulsions and sores. The flannel illustrations are excellent. The series is designed for the West African Savannah.

* Morley, D.C. (1973) Paediatric priorities in the developing world. Includes a chapter on measles and its management.

* Morley, D.C. (1976) Severe measles. 24 slides with explanatory text. Explains why measles is such a severe and killing disease in developing countries. Describes the sequelae of diarrhoea, bronchopneumonia, blindness, cancrum oris, exacerbation of TB etc. A cassette tape is also available.

Sterling Health (?1980) Coping with childhood infections (UK). Helping your doctor and yourself. No.4 of a series. A table shows how to distinguish between rashes.

Care of the child with worms

Eshuis, J. and Monschot, P. (1978) Communicable diseases. Chapter 5: Helminth diseases. Includes drawings of the life cycles and manner of transmission of: ascaris, Enterobius vermicularis, hookworm, strongyloides, Taenia saginata, Echinococcus.

The prevention and management of each disease is discussed including the differentiation of the eggs and worms. Special attention is paid to hookworm and anaemia in mothers and children, and ascaris in children.

King, M., King, F., and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1. Chapter 21: Worms. "He has passed a worm."

King, M., King, F., and Martodipoero, S. (1979) Primary child care. A set of 240 slides and explanatory script. 35pp. A cassette tape is also available.

This set of slides covers most common childhood conditions. Slides PCh18 - 23 include ascaris, tapeworm, trichuris and hookworms.

Marsden, P. (1978) American helminths. 24 slides with explanatory text. A cassette tape is also available. Includes flukes (schistosomes), tapeworms, (Hydatid cysts, cysticercosis), roundworms (hookworms, threadworms) and filaria.

Marsden, P. (1978) Protozoa of South America. 24 slides with explanatory text. A cassette tape is also available. Includes malaria, trypanosomiasis, leishmaniasis, Amoebiasis, Balantidium coli, Toxoplasmosis, pneumocystosis carinii.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals: pp.20-21.

PARASITE INFESTATION

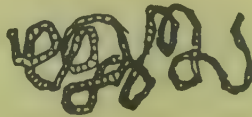
Roundworms



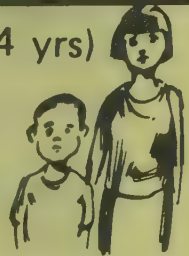
Threadworms



Flatworms
(Tapeworms)



5. Children (7-14 yrs)
1½ tsp after
morning and
evening meal

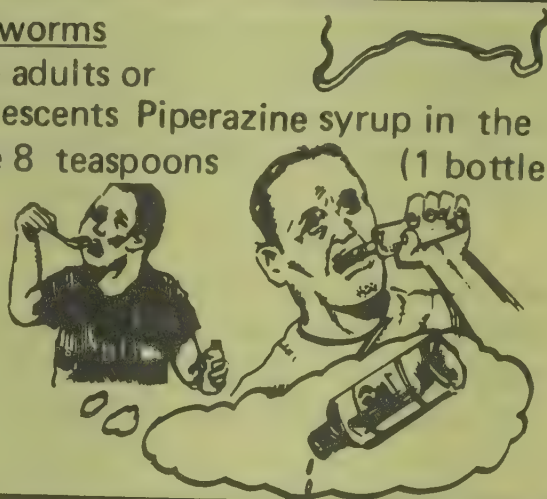


6. Children (7-14 and
up) 2 tsp after
morning and
evening meal



Roundworms

1. Give adults or
adolescents Piperazine syrup in the
dose 8 teaspoons (1 bottle)



Threadworms

2. Give treatment over a
period of several days,
as follows:

Infants (9 mos-2 yrs)
½ tsp after morning and



evening
meal



3. Children (2-3 yrs)
½ tsp after daily
meals

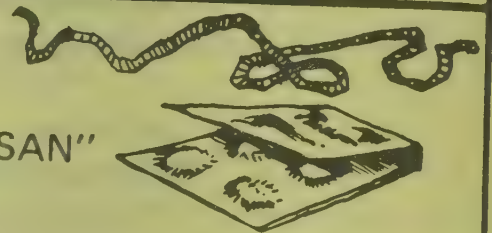


4. Children (4-6 yrs)
1 tsp after
morning and
evening meal



Tapeworms

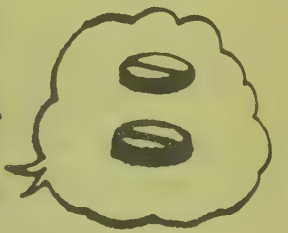
Give "YOMESAN"



1. Adults and children
over 6 yrs: 4
tablets in a
single dose



2. Children (2-6 yrs).
2 tablets



3. Infants (under 2 yrs):
1 tablet

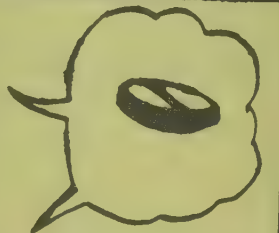
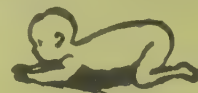


Fig. 7.16.

Care of the child with skin problems

- * Balldin, B., Hart, R., Huenges, R., and Versluys, Z. (1981) Child health; a manual for medical assistants and other rural health workers.
Chapter 15: Diseases of the skin. These are caused by bacteria, fungus, insect bites and parasites, allergic reactions of the skin, viruses. Tumours also occur on the skin. Each of these conditions is explained. Bacterial infections (impetigo and Tropical ulcer) are dealt with, including the symptoms, signs and the treatment. Ringworm is the only fungal skin infection explained. Of parasitic problems, scabies, louse infestation, Jigger, fly larvae and insect bites are dealt with. Two forms of eczema and dermatitis - the infantile form and drug eruptions - get special attention.

- * Eshuis, J. and Monschot, P (1978) Communicable diseases. Chapter 1: Contact diseases. This is a chapter on skin conditions which deals with scabies, pediculosis, fleas, fungal infestations, candidiasis.

- * Exchange, Newsletter of the National Eczema Society, UK. A self-help support group for parents of children with eczema (and also for adults). It's very useful newsletter. Combines a "readers' exchange" of successful ideas and approaches or hazards experienced from overuse of drugs, with a "specialist viewpoint". Dermatologists, immunologists etc. review recent research data.

- * King, M., King, F., and Martodipoero, S. (1979) Primary child care. A set of 240 slides and explanatory script. 35pp. A cassette tape is also available.
Slide nos. PCe 1-24. This is the fifth set of slides in a series of 240 slides based on the book "Primary Child Care" by the same authors. Includes mainly skin problems of children; scabies, ringworm of the scalp, Tinea versicolor, Herpes simplex and Zoster, chickenpox.

- Shrank, A. (1970) Common skin diseases in children in the tropics.
24 slides with explanatory text. A cassette tape is also available. A range of skin problems found in the young child, e.g. ringworm, pyoderma, leprosy, and injuries, are reviewed. The author believes that skin problems in children are twice as common as in adults. The management of the skin problem is mentioned.

- Shrank, A. (1974) Skin diseases in children in temperate climates.
24 slides and a script. A cassette tape is also available. In the tropics, skin infections and parasitic infestations are common; whereas eczema, psoriasis and naevi form the majority of skin problems in temperate areas. The signs, symptoms, diagnosis and management of the common skin problems in the temperate zone are explained in a simple manner.

- Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals.

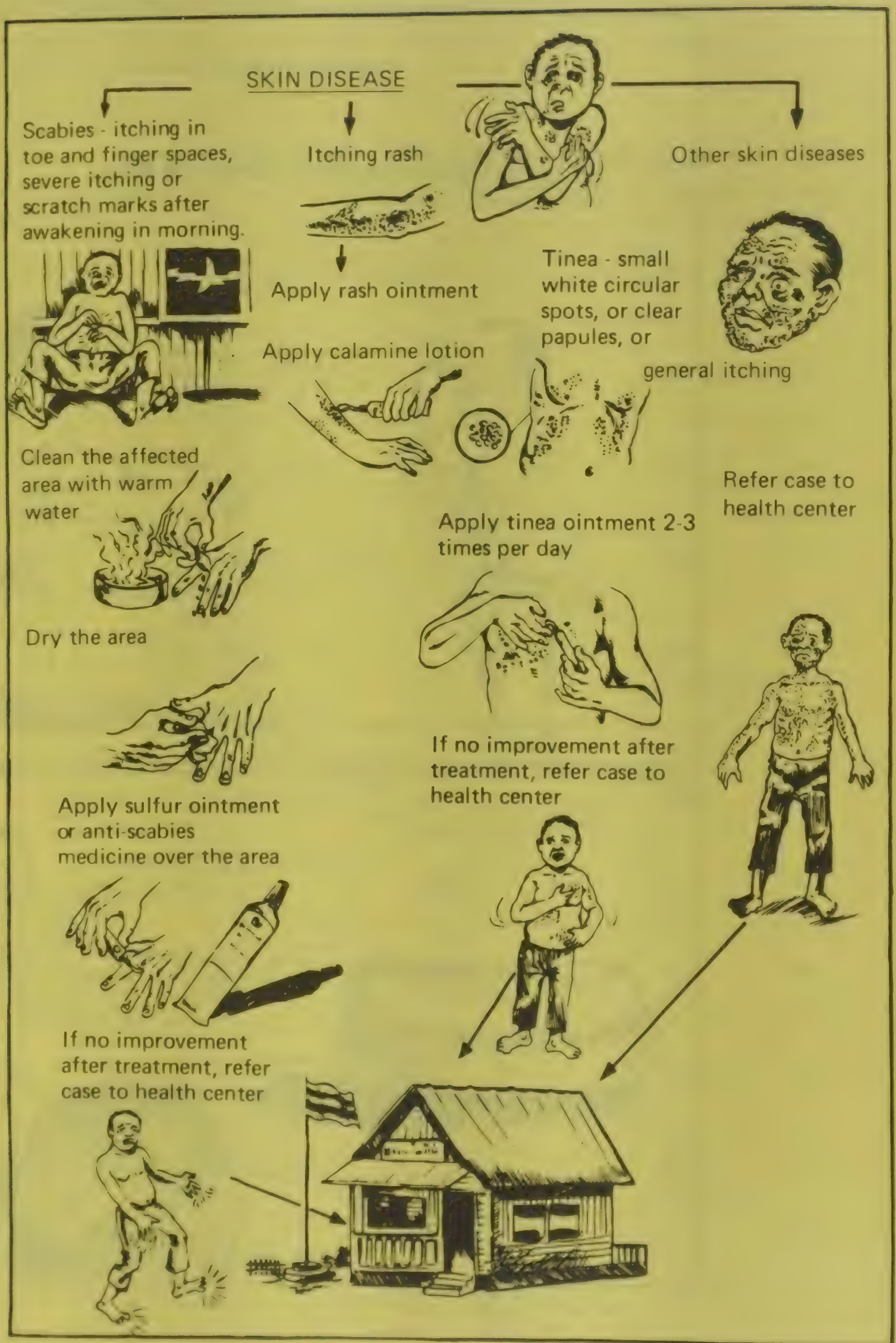


Fig. 7.18.

Health Education

1. Skin conditions, scabies, and tinea are easily contagious through close contact or using common clothes of infected individuals.



2. When bathing, use soap since this will help prevent skin disease.

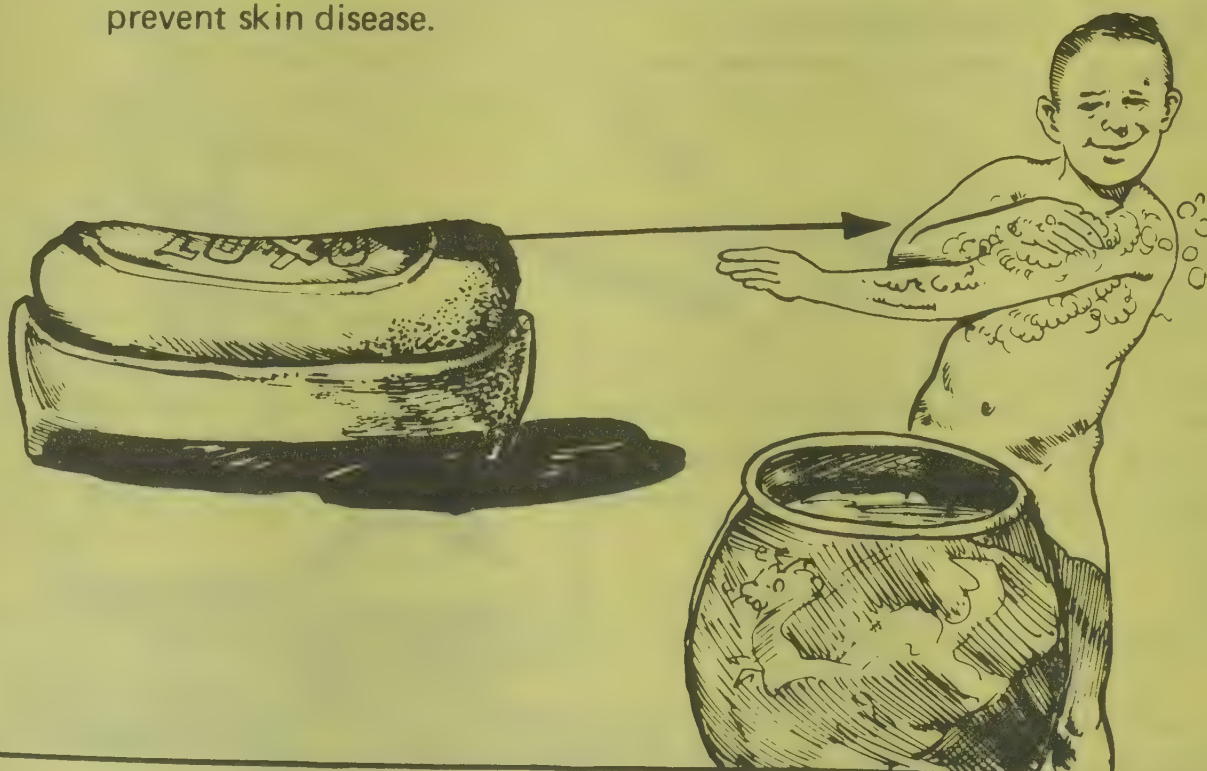


Fig. 7.19.

* Werner, D. (1977) Where there is no doctor.
 Chapter 15: Skin problems. Includes a guide to their
 identification and management.

SKIN PROBLEMS – A Guide to Identification

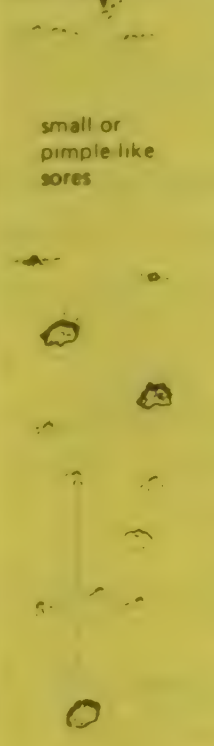


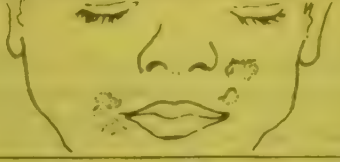


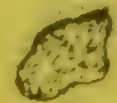






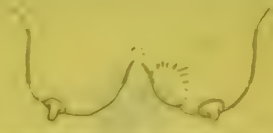

IF THE SKIN HAS:	AND LOOKS LIKE:	YOU MAY HAVE:	SEE PAGE
 <p>small or pimple-like sores</p>	<p>Tiny bumps or sores with much itching—first between fingers, on the wrists, or the waist.</p> 	scabies	199
	<p>Pimples or sores with pus or inflammation, often from scratching insect bites. May cause swollen lymph nodes.</p> 	infection from bacteria	201
	<p>Irregular, spreading sores with shiny, yellow crusts.</p> 	impetigo (bacterial infection)	202
	<p>Pimples on young people's faces, sometimes chest and back, often with small heads of pus.</p> 	acne, pimples, blackheads	211
	<p>A sore on the genitals, without itching or pain.</p> 	syphilis venereal lymphogranuloma	237 238
 <p>a large, open sore or skin ulcer</p>	<p>A large chronic (unhealing) sore surrounded by purplish skin—on or near the ankles of older people with varicose veins.</p> 	ulcers from bad circulation (possibly diabetes)	213 127
	<p>Sores over the bones and joints of very sick persons who cannot get out of bed.</p> 	bed sores	214
	<p>Sores with loss of feeling on the feet or hands. (They do not hurt even when pricked with a needle.)</p> 	leprosy	191
 <p>lumps under the skin</p>	<p>A warm, painful swelling that occasionally breaks open.</p> 	abscess or boil	202
	<p>A warm, painful lump in the breast of a woman breast feeding.</p> 	mastitis (bacterial infection), possibly cancer	278 279
	<p>A lump that keeps growing. Usually not painful at first.</p> 	cancer (also see lymph nodes)	279 88
	<p>One or more round lumps on the head, neck, or upper body (or central body and thighs).</p> 	river blindness (also see lymph nodes)	227 88

Fig. 7.20.

Care of the child with red eye

* Australia, Health Education Council, Perth (1961) Eye care. A useful leaflet although it is rather old. Includes a discussion of trachoma and conjunctivitis, plus a practical checklist of preventive measures.

* CHILD-to-child Programme (?1982) Activity sheets: Let's find out how well children see and hear. Eng. Fr. Sp. Port. Arabic.

An activity sheet for helping children find out how well they see and hear.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals. Conjunctivitis management: p.17.

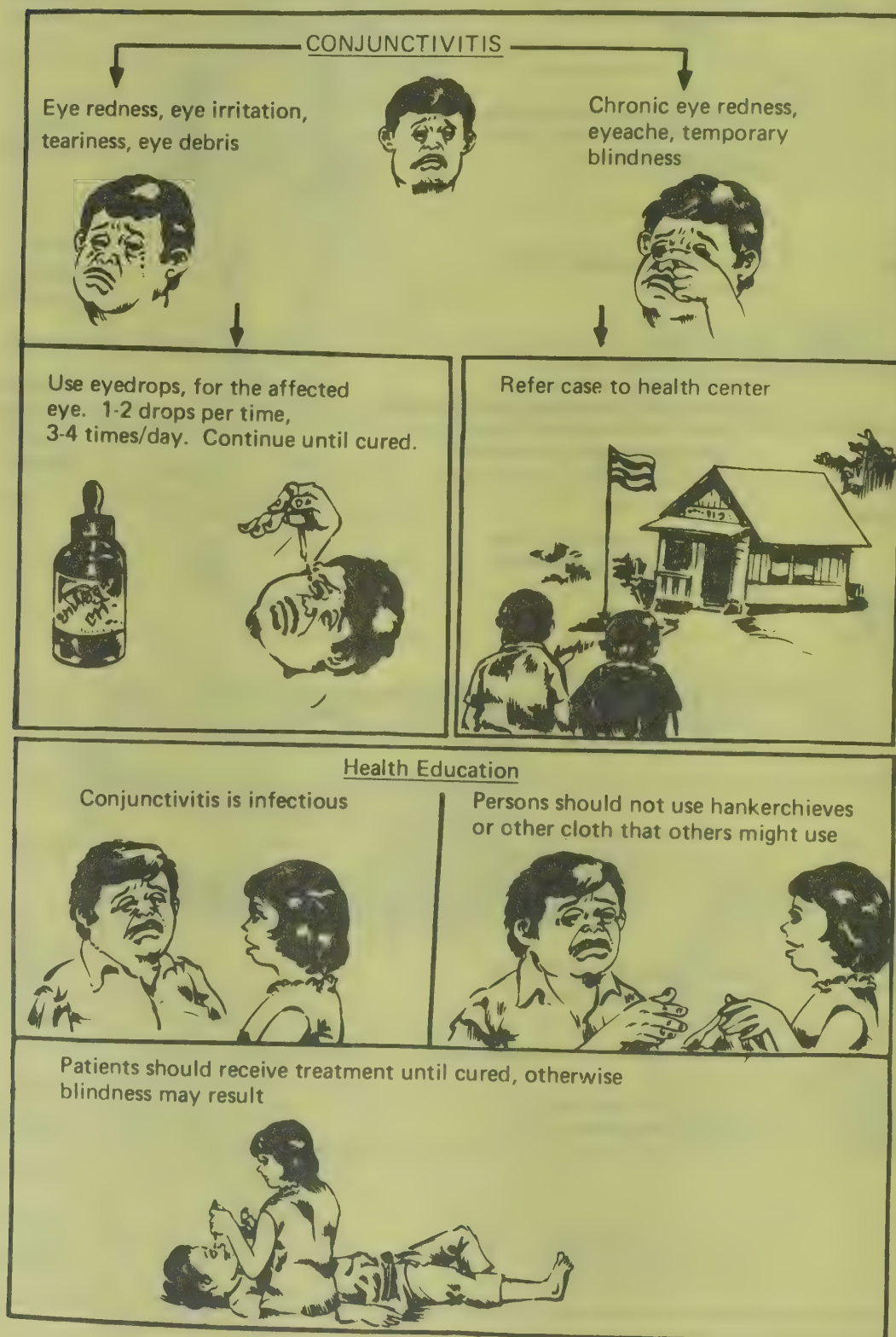


Fig. 7.21.

- * WHO/PBL (In preparation) Primary health care poster.
A chart indicating primary care for various eye conditions.

7.10. Care of the child with sickle cell disease

- * Lesi, F.E.A. (1980) Sickle cell disease, a handbook for patients, counsellors and primary health care practitioners. A booklet written because of the perpetual requests for information about sickle cell disease, from patients and their parents. Includes sections on: what is sickle cell disease? how does one get the disease?; who is a sickler?; what brings about a crisis?; how are sicklers looked after?; and on counselling for vulnerable families.

7.11. Care of the child with wheeziness

- * Hilton, S. (?1980) Understanding asthma. Includes causes and treatment of asthma. Written for patients and their parents.

7.12. Care of the child with tuberculosis

- * Botswana, Ministry of Health (?1982) Let's talk about TB. An excellent booklet with delightful cartoon illustrations of a story. "After all story telling is a traditional Tswana way of transmitting ideas!". Part 1: What is tuberculosis?; Part 2: How do you know that you have TB?; How can TB be cured?; Part 3: How can we prevent TB from spreading?; How can we protect ourselves from TB?; Part 4: Community action against TB.



Fig. 7.22.

* de Tavera, M.P., Saturay, F.V., Marfil, L.P., Jose, L. and Garilao, J. (1978) A model of supervised community participation in the prevention and short term therapy of TB among the poor in Asia.

This account is derived from experiences in the Philippines.

* Eshuis, J. and Monschot, P. (1978) Communicable diseases. Chapter 8: Tuberculosis and leprosy. The section on tuberculosis states: "TB is a disease of poor people," thus emphasising the social nature of the disease rather than the germ. However how the bacteria spreads and affects the body, and ways of arriving at a diagnosis are covered at length. The management and treatment of patients are shown. Tuberculin tests and the administration of BCG vaccines are recommended. The section on leprosy stresses the early recognition of the disease and its early treatment. Disability due to leprosy should be managed properly and some procedures are shown in pictures.

* Kennedy, M. (1979) Standard management of tuberculosis and leprosy in Papua New Guinea, a handbook for health workers. 128pp.

This book represents the essence of many years' work in the field.

* Miller, F.J.W. (1975) Natural history of tuberculosis in childhood.

24 slides with text. A cassette tape is also available. Shows the course which untreated primary tuberculosis infection takes, including complications.

* Miller, F.J.W. (1982) Tuberculosis in children, evolution, epidemiology, treatment, prevention. Excellent reference material.

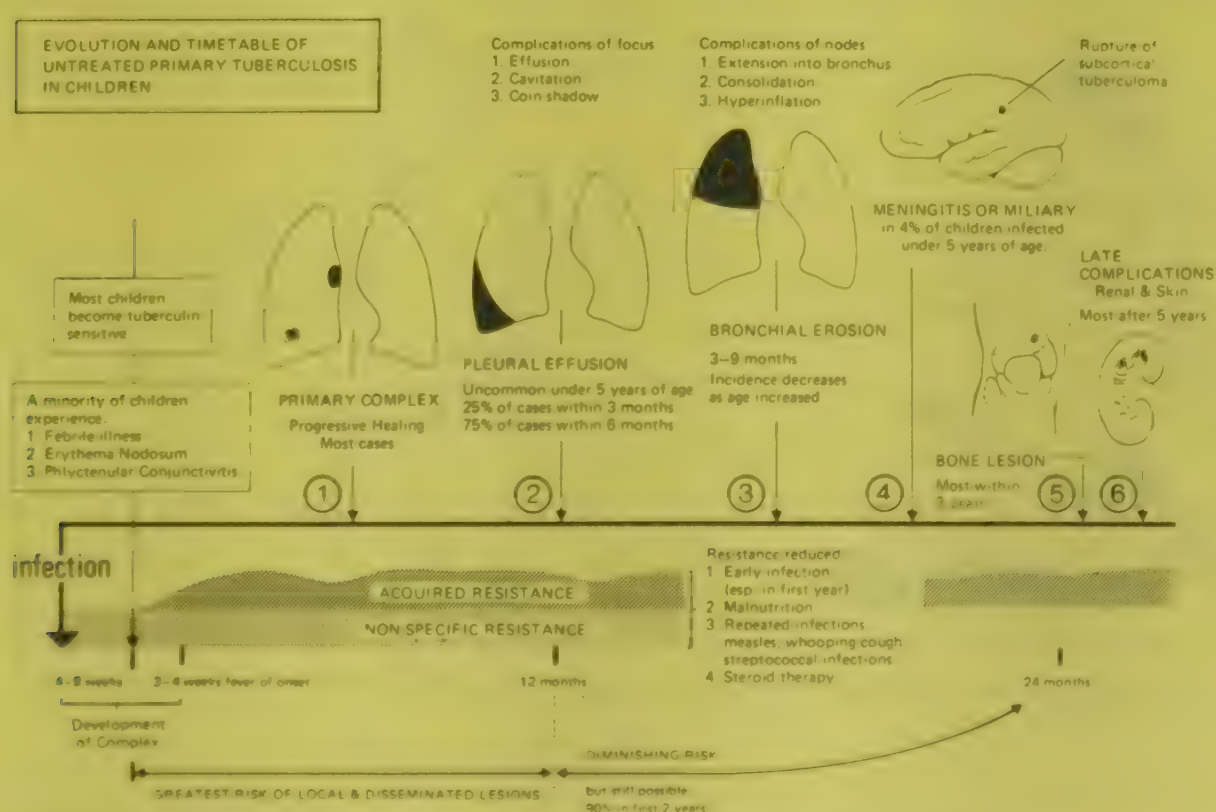


Fig. 1.2 Evolution and Timetable of untreated primary tuberculous infection

Fig. 7.23: p.12.

It is important to know the natural history of tuberculosis so that one can attack the disease at the appropriate time.

Seal, R. (1976) Pathology of tuberculosis in childhood. 24 slides with text. A cassette tape is also available. Slides 1-3 show the tissue response to M. tuberculosis; slides 4 to 7 show the complications of primary tuberculosis spread by blood; slides 8 to 11 show complications of the lung and infection without perforation of the bronchi; slides 12 to 15 show bronchial perforation; slides 16 to 18 show what happens to the segmented lesion; slide 19 shows lung damage; slide 20 shows the involvement of organs near the lung; slide 21 is about late complications of bronchial diseases; slide 22 is a summary; and slides 23 and 24 show post-primary lesions.

Tanzania, Ministry of Health (1981) Manual of the national tuberculosis/leprosy programme in Tanzania. A simple text on the diagnosis, treatment and management of TB and leprosy for Tanzanian health workers. Diagrams showing likely sites for leprosy, the stages of leprosy, (tuberculous lepromatous) are explained in simple terms. The appendices cover laboratory diagnosis, registration and notification.

Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals.

Health Education (cont'd)

3. Lung disease, or TB, is curable if treated, and if patient follows doctor's advice



4. Cover mouth and nose when you cough or sneeze



5. Do not spit on the floor. Spit in containers with covers



Fig. 7.24.

Care of the child with leprosy

* Browne, S.G. (1983) The diagnosis and management of early leprosy for medical practitioners. Revised edition.

* Browne, S.G. (1976) Memorandum on leprosy control.

* Buchmann, H. (1978) Leprosy control services as an integral part of primary health care programmes in developing countries. 77pp.

An excellent analysis of the tasks which need to be done for leprosy care and how these might fit within primary health care.

Eshuis, J. and Monschot, P. (1978) Communicable diseases. See p.299 ff.

Jopling, W.H. and Ridley, D.S. (1976) The classification of leprosy.

A set of 24 slides to show how a new understanding of immunology leads to the improved classification of leprosy.

* Kennedy, M. (1979) Standard management of tuberculosis and leprosy in Papua New Guinea. A handbook for health workers. 128pp.

* King, M., King, F., and Martodipoero, S. (1979) Primary child care. A set of 240 slides and explanatory script. 35pp. A cassette tape is also available.

Slides no. PCf 1 -24. This is the sixth set from a series of 240 slides from the book "Primary Child Care" by the same authors. It deals with leprosy - lepromatous and tuberculoid, TB, burns in children, foreign bodies, meningitis, and eye problems including conjunctivitis.

* Leprosy Mission International (1980) Teaching and learning materials, revised book list. Many teaching and learning materials were tested before inclusion in this list.

McDougall, C. (1979) Leprosy in childhood. 24 slides with text. A cassette tape is also available. Slides 1 - 5 give a definition of leprosy, its world distribution etc; slides 6 and 7 are about nerve damage in leprosy "what matters above all in clinical leprosy is nerve damage"; slide 8 shows the symptoms (claw hand, discolouration of the skin, scar); slide 9 shows patients with facial nerve involvement; slides 10 and 11 show lepromatous leprosy; slide 12 shows tuberculoid leprosy; slide 13 depicts both lepromatous and tuberculoid - intermediate - forms. The other slides show further elaborations of the disease. The set is completed by a questions and answers review of the material.

* Oxfam/Lepra (1984) Leprosy: teaching and learning material: a package of 11 documents. Intended for staff involved in a teaching programme.

Tanzania, Ministry of Health (1981) Manual of the national tuberculosis/leprosy programme in Tanzania.

Uganda, Ministry of Health, Health Education Division (1972)
Leprosy can be cured. Mimeo.
Useful but probably out of print.

VHAI (1978) Better care in leprosy. Booklet.
An illustrated booklet in simplified English for village health workers to teach the local community.

VHAI (1978) Teaching village health workers, a guide to the process; a teaching pack.
Lesson plan unit V covers leprosy. The two messages emphasised are that ulcers and deformities can be prevented and injuries to feet and hands must be avoided. Covers what to teach, a review of the main points, and practice guidelines.

Werner, D. (1977) Where there is no doctor.
Emphasises the prevention of damage to hands and feet. Most deformities with leprosy can be prevented.
P.192 ff explains that deformities develop because the person with leprosy cannot feel the pain of a blister etc. Suggested remedies include:

1. Protecting hands and feet from things that can cut, bruise blister or burn them:

"Do not go barefoot, especially not where there are sharp stones or thorns. Wear shoes or sandals. Put soft padding inside shoes and under straps that may rub. When you are working with your hands, or cooking meals, wear gloves. Never pick up a pan or other object that might be hot without first protecting your hand with a thick glove or folded cloth. If possible, avoid work that involves handling sharp or hot objects. Do not smoke.



Fig. 7.25.



Fig. 7.26.

2. At the end of each day (or more often if you work hard or walk far) examine your hands and feet very carefully - or have someone else examine them. Look for cuts, bruises, or thorns. Also look for spots or areas, on the hands and feet, that are red, hot, swollen or show the beginnings of blisters. If you find any of these, rest the hands or feet until the skin is completely normal again. In this way the skin will become calloused and stronger, instead of blistered and raw. Sores can be prevented.

3. If you already have an open sore, or one forms, keep the part

with the sore very clean and at rest until it has completely healed. Then take great care not to injure the area again".

7.14.

Dental care

* AHRTAG (1983) Dental Health Newsletter.

A very useful publication. Emphasises the underlying causes of dental disease and gives many ideas for taking action to prevent dental disease occurring.

AHRTAG (1981) Assisting dental education and dental public health in developing countries: a symposium. 77pp.

Dickson, M. (1984) Where there is no dentist.

A simple, practical manual on the care and treatment of the teeth. Includes many good diagnostic charts.

* Halestrap, D.J. (1975) Simple dental care for rural hospitals.

* WHO, Oral Health Unit (?1982) Common oral diseases; prevention and emergency care; a manual for teachers.

This course is intended to provide basic knowledge on the prevention of common oral diseases and the treatment of oral emergencies for health workers who have little or no knowledge of oral diseases and who are faced with attending to those suffering from them. Included are four modules:

1. Common oral diseases: causes and prevention.
2. Minor oral surgery.
3. Oral medicine.
4. Temporary dressings; alveolitis (dry sockets), pericoronitis.

8. Care of the injured child and prevention of further accidents especially at home.



8. Care of the injured child and prevention of further accidents especially at home.

Books in this field tend to cover many types of accidents, often focusing on immediate care and only rarely covering prevention. The general sources listed below cover all the topics well.

8.1. General sources of information on accidents, first aid, care, and prevention

* **Aarons, A., Hawes, H. and Gayton, J.** (1979) **CHILD-to-child.** A book.

Chapter 5: Accidents. How children can help younger siblings prevent accidents, using stories and games.

* **American Visuals Corporation** (1957) **Potential poisons in your home,** by Helen R. Mayne. 14pp.
An excellent booklet pointing out "potential poisons one found in every room..." Children account for a quarter of the fatalities in the thousands of accidental poisonings in the US each year. "A poison can be any substance improperly used, for example, shampoo if swallowed in large quantities."

* **British Red Cross Society** (1981) **First aid manual.** 15th impression.
This book, although not aimed specifically at MCH emergencies, includes such topics as: (1) removal of obstruction in infants; (2) removal of obstruction in children; (3) convulsions of infants and young children; (4) burns and scalds; (5) poisoning; (6) hypothermia; (7) emergency childbirth. It is well illustrated.

* **Eaton Publications** (?1983) **Safety in the garden.** Leaflet E.18.

de Glanville, H., Schilling, R.S.F. and Wood, C.H. (eds.) (1979, reprinted 1983) **Occupational health.**
Chapter 13: Accident prevention. An accident to a worker is a loss to himself, the employer and the country as a whole. The scope of the problem is illustrated by the following figures from Tanzania: in 1971 there were 4021 reported injuries in factories: 65 of them were fatal, and 521 so disabling that workers could not return to their previous job. Most accidents occur due to human error, such as negligence, faulty behaviour, risk-taking, falls of objects/persons etc. Poor working conditions, dangerous parts of machinery and inadequate training also contribute.
An accident prevention "programme" includes: the provision of personal protective equipment; a managerial policy to provide adequate mechanical guarding for all dangerous machinery; and a works safety committee, headed by a safety officer. Two strategies are proposed to prevent accidents: (1) safe-place strategy (good housekeeping, engineering control methods, effective ventilation); (2) safe-person strategy: (trained workers, protective clothing such as goggles, safety boots, breathing apparatus).

Guild of Health Education Officers, UK (1980) Emergency first aid.

* Health Education Council, UK (?1975) Danger! Deadly sweets! Your medicines can be a child's poison. A leaflet which gives instructions on how to avoid accidental poisoning from medicines.

* Health Education Council, UK (?1975) Home safe home. Pamphlets 1 and 2. Hints on preventing accidents in the home. Illustrated lists of action needed to prevent accidents in the bathroom, the hall, the stairs, the passage, the living room, the bedroom, the kitchen, and the home in general.

* Health Education Council, UK (?1960s) Safety for Sally and Sam. Describes what sort of activity, and therefore what accidents, can be expected in children aged:

- (a) up to 6 months
- (b) around 12 months
- (c) around 2 years
- (d) around 3 years
- (e) around 4 years

It is written from the children's, i.e. Sally and Sam's point of view, with many positive suggestions for play rather than advice on 'don't do this', 'mind that'.

* Health Education Council, UK, and Scottish Health Education Group (1982) Play it safe, a guide to the prevention of children's accidents.

An illustrated booklet with photographs and line drawings showing how child accidents happen. It was produced to accompany a BBC TV series of ten short programmes (about 5 minutes each) shown at peak viewing times. The booklet covers choking and suffocation; scalds; falls; poisoning; burns; drowning; cuts; accidents at play, on the roads, on bikes, in cars, emergency first aid; the first aid kit. Very useful for Europe.

* International Children's Centre (1980) Child abuse and neglect. Leaflets. Eng. Fr. Sp. Child abuse includes physical damage, emotional stress, sexual abuse and exploitation (child labour); the authors assert that it is not a disease to be treated, but a disorder. These documents are aimed at professionals (midwives, social workers, nurses, teachers), parents and policy makers.

Jelliffe, D.B. and Stanfield, J.P. (1978) Diseases of children in the subtropics and tropics. 3rd ed. Chapter 35 Accidents and poisoning.

Most accidents happen to children rather than adults. Issues discussed include falls, burns, road accidents, drowning, poisoning, violence. The methods of prevention for accident prone environments, drainage, wells, pits, bridges, rubbish disposal areas, etc. City councils and prevention committees. Safety teaching.

* **International Children's Centre** (1979) Prevention of child accidents at home. Booklet. Eng. Fr. Sp. Arabic.

Presents the following facts:

- (1) Accidents are fast becoming the greatest single cause of child deaths
- (2) For every fatal accident, between 200 and 900 children are admitted to hospital
- (3) For every fatal accident, between 1-4 handicaps result
- (4) Over half of child accidents occur with an adult present.

Supplements to the booklet are available for three audiences: technical notes for university and other teaching staff; technical notes for kindergarten and elementary schoolteachers and parents (in developed countries); notes for the guidance of administrators and those responsible for decision making (in developed countries).

King, M. (ed.) (1982) Primary traumatology: Part 2: The rest of trauma. Experimental edition only.

This book describes the treatment of common injuries by non-specialist doctors in district hospitals in the developing world. The aim is to de-mystify surgery: to assemble a systematic, detailed and comprehensive account of everything that may be done for an injured patient. It includes: the preventability of trauma; the severely injured patient; the airway; shock; wounds; injuries to vessels, common nerves and tendons; amputations; skin grafts and flaps; burns; atomic trauma; eye injuries; and injuries to face, head, spine, chest, limbs, abdomen, etc: also the use of plaster and traction.

Two other books: "Primary Anaesthesia" and "Bony Injuries" have already been produced in experimental versions.

* **Mothercare, Health Education Advisory Service** (?1983)
Safety in the home for babies and toddlers; Safety at play.
Leaflets.

* **National Association for Maternal and Child Welfare (NAMCW), UK** (1973) Keep them safe and sound (babies and young children).
Leaflet.

Royal Society for the Prevention of Accidents (ROSPA) (1975)
Baby safety (BS) and Toddler safety (TS). Slide sets with lecture notes and tape recordings.

45 slides on baby safety, 56 slides on toddler safety. They are useful, although they tend to emphasise the negative - 'Never do this', - rather than the positive - 'Do this instead'. Useful within Europe.

* **Royal Society for the Prevention of Accidents (ROSPA)**
(quarterly) CARE - a home safety journal.
This journal is the only one of its kind and deals with all aspects of safety measures and public education to prevent accidents at home.

* **Royal Society for the Prevention of Accidents (ROSPA)** (1973)
Dustbin dangers and ideas for safe disposal. Free leaflet.

* St. John Ambulance Association (1972) First aid manual.
3rd edition.

A reference book on first aid.

Skeet, M. (1984) First aid.

* Uganda, Ministry of Health, Health Education Division (1971)
Burns and scalds.

Burns and scalds have become the most common home accidents, mostly among children under 5 years. The causes and prevention of each are listed. Causes include playing with fire and boxes of matches; playing near fire; sitting near the fire to get warm; cooking in the living house; handling hot liquid; living in a home with overgrown grass around it. This is one of the few examples geared to developing countries that was found. It may be out of print but is worth reproducing as an example of what can be produced locally.

* US, Maryland Accident Prevention Unit (?1970s) Child safety pamphlet.

An excellent leaflet. It covers steps in baby/child development and their implications for safety. There are many positive suggestions for suitable toys at: (a) birth to 6 months; (b) 6 months to one year; 2-3 years; 3-5 years.

* Werner, D. (1977) Where there is no doctor.

Chapter 10: First aid. A broad approach to handling emergencies that includes fever (keep cool); shock (lie calm); drowning (mouth to mouth resuscitation); bleeding (apply pressure); cuts (use stitches); fractures (reposition); snakebite and scorpion sting.

* Zaire, Bureau d'etudes at de recherches pour la promotion de la sante (no date) La sante de vos enfants - Booklet 14; Peut-on eviter les accidents? - Booklet 20. Fr.

8.1.1.

Preventing accidents on the road

Little material has been located. There must be much available from the specialist organisations.

UK, Metropolitan Police (?1975) Be sure your child is safe on the roads. Use this leaflet to teach a lesson for life. A pamphlet which explains safe are of 2-4 year-olds; the first teaching of the Green Cross Code (road safety) to 5-6 year-olds; teaching the way to cross busier roads to 7-9 year-olds.

* UK, Metropolitan Police (?1980) Crash course: advice to motorists on action to prevent further accidents after a road crash.

8.2.

Child burns, care and prevention

* Aarons, A., Hawes, H. and Gayton, J. (1979) CHILD-to-child. A book.

"Burns. At once put in cold water. Put the whole body in water

if necessary. If the burn is bad, boil a little vaseline, put it on a clean cloth and loosely cover the burn. Never use grease or butter. Burns must be kept clean and are best left uncovered

P.51: "Spreading the idea. Children should not try to do everything at once. For two weeks they could have a campaign against burns. Some time after the first campaign is finished they could start another on road accidents and so on."

FRIEZE PICTURE: CHILDREN'S STORY



Fig. 8.1.

* British Red Cross Society (1981) First aid manual. 15th impression.

Almost all major emergencies are covered, with illustrations. There are sections on burns and poisoning.

* Health Education Council, UK and Scottish Health Education Group (1982) Play it safe, a guide to the prevention of children's accidents.

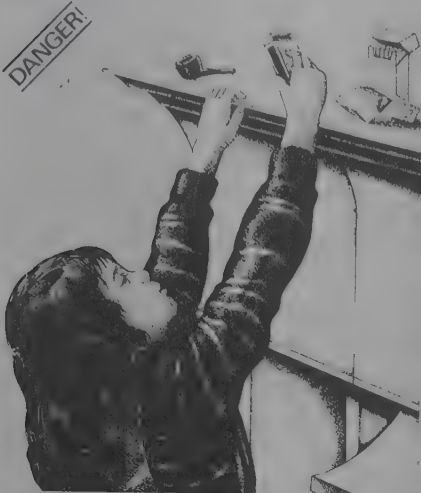
Pp.14-17: Burns, including those caused by: electric fire, iron, matches, hanging clothes on a fireguard, petrol and paraffin containers left within reach of children, inflammable night wear, boiling pans, ashtrays with lighted cigarettes, sockets with too many plugs connected, frayed wire, and fireworks. Also discusses what to do in an emergency, and first aid for burns.

How to prevent accidents

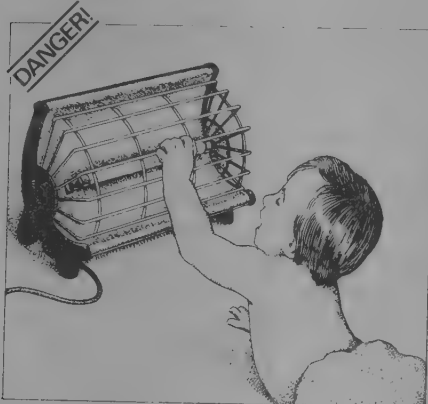
Around the house

Switch the iron off immediately you finish ironing and put it out of children's reach. Remember too that children might pull at the iron flex.

Never leave children alone in the house.

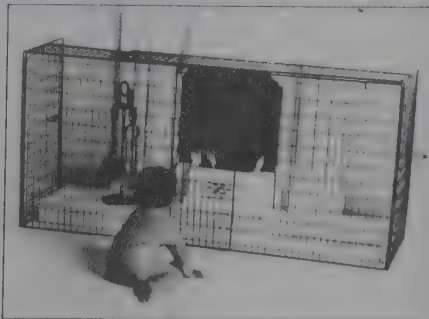


Keep matches and lighters well out of their reach.

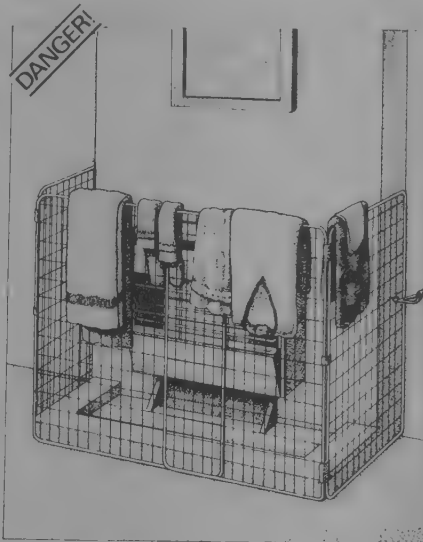


Never take off the guards that are fitted to gas or electric fires. Remember that crawling babies will

try to grab hold of anything they can reach, such as a glowing fire element.



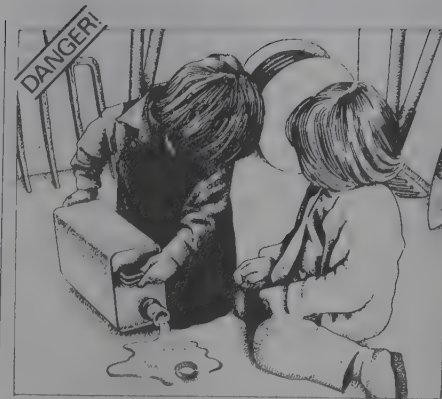
Use special safety fireguards in front of all fires. These should have a cover on top and should be fixed to the fireplace or wall. Use them even before your baby starts to crawl. You never know when your baby will make that first dangerous journey.



Don't lean anything against, or hang anything on, fireguards.

Don't use movable electric fires in the bathroom.

Don't hang a mirror on the wall above a fire. Anybody going close to look in the mirror may be burnt.



Keep petrol and paraffin away from children and don't store in large quantities.



When you buy children's night clothes or dressing gowns, try to make sure they are flame-resistant. You can be sure that all children's night dresses made in this country are flame-resistant. For dressing gowns and other clothes, remember that flimsy cotton is the most dangerous material.

Fig. 8.2.

King, M. (ed.) (1982) Primary traumatology. Part 2. See Section 8.1. for details.

Includes: the assessment of burns; fluid requirements; feeding someone with burns; methods of treatment; prevention and treatment of contractures.

* Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals (I-IV). Volume IV of this series of manuals deals with the management of burns and scalds, although not specifically for children.

* Uberoi, I.S. et al. (1974) Child health care in rural areas. A manual for auxilliary nurse midwives. 234pp. Includes the management of wounds, burns, bites. Useful for rural situations.

Uganda, Ministry of Health, Health Education Division (1971) Burns and scalds.

WHO (1980) The primary health worker; working guide; guidelines for training; guidelines for adaptation.
 "Be careful: remember that it is mainly children who get burns because they do not realise the danger of a fire or boiling water."

BURNS



Fig. 8.3.

8.3.

Child poisoning, care and prevention

* British Red Cross Society (1981) First aid manual. 15th impression.

Eshuis, J. and Monschot, P. (1978) Communicable diseases.
 "Food poisoning. 1. Food poisoning is a term applied to an acute intestinal disease acquired by the consumption of food or water.

The cause may be an intoxication with chemicals (heavy metals, fluoride, and others), toxins produced by bacterial growth, and a variety of organic substances that may be present in natural food.

Food poisoning is usually recognised when all members sharing the same food fall sick within a short time."



Food poisoning occurs among people who share the same meal

Fig. 8.4.

* Health Education Council, UK (?1975) Danger! Deadly sweets! Your medicines can be a child's poison.

* Health Education Council, UK and Scottish Health Education Group (1982) Play it safe, a guide to the prevention of children's accidents.

Pp.12-13: Poisoning. Includes: pills and medicines; household and garden chemicals, poisonous plants. There is a very useful photograph showing the similarity of many drugs and sweets.

* Jelliffe, D.B. (1974) Child health in the tropics; a practical handbook for medical and paramedical personnel. 4th edition. 170pp. Eng. Sp.

Chapter 7 of this book is devoted to poisoning and injuries, and ways of protecting children from accidents.

King, M., King, F., and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1.

Chapter 14: Injuries and poisoning. Children are most in danger of having injuries or poisoning. The prevention of accidents as well as the management aspects are well presented here.

* Royal Society for the Prevention of Accidents (ROSPA) (?1982) Your home is dangerous. Leaflet.

Schull, C.R. (1980) Diagnosis and treatment of common health problems of adults in Papua New Guinea. 2nd edition.

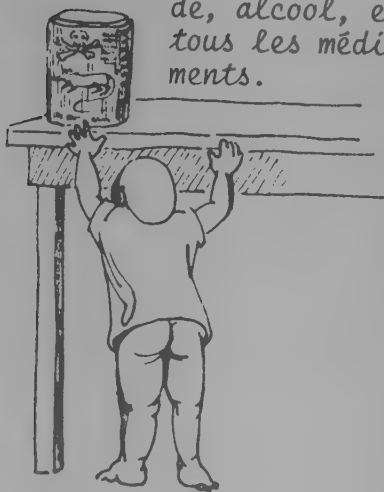
The section on poisoning deals with swallowed poisons and drug overdose.

* Werner, D. (1977) La ou il n'y as pas du docteur. (Where there is no doctor). Fr. edition with West African illustrations.

EMPOISONNEMENT

Beaucoup d'enfants sont morts pour avoir avalé des produits toxiques. Pour protéger vos enfants, prenez les précautions suivantes:

RANGER TOUT PRODUIT DANGEREUX
HORS DE LA PORTEE DES ENFANTS
leau de javel, insecticide, raticide, alcool, et tous les médicaments.



NE JAMAIS METTRE DU PETROLE, DE L'ESSENCE OU AUTRE PRODUIT DANGEREUX DANS DES BOUTEILLES DE SODA, COCA COLA, les enfants ne font pas la différence et peuvent les boire.

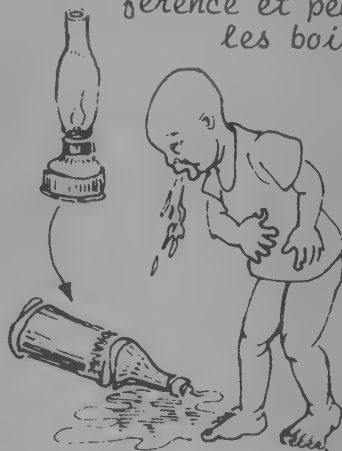


Fig. 8.5.

"Parmi les produits toxiques les plus connus, on trouve:

eau de javel	alcool	insecticide
petrole	tabac	raticide
essence	tous les medicaments	lessives

Traitement:

Au moindre soupcon d'empoisonnement, sans perdre de temps:
Faire avaler au patient beaucoup de lait, des oeufs battus ou de la farine diluee dans de l'eau.

Provoquer des vomissements en lui enfoncant un doigt au fond de la gorge ou en lui faisant boire de l'eau savonneuse ou salee. Lui donner du lait, des oeufs battus ou de la farine diluee dans de l'eau jusqu'a ce que les vomissures soient claires."

8.4.

Child cuts and wounds: care and prevention

* Armon, P.J. (1980) The use of honey in the treatment of infected wounds. *Tropical Doctor* 10 (2): p.91.
Honey has long been used to treat cuts and sores, e.g. see Werner, D. (1977) Where there is no doctor. This article reports its effective use by medical staff.

* British Red Cross Society (1981) First aid manual. 15th impression.

* Health Education Council UK, and Scottish Health Education Group (1982) Play it safe, a guide to the prevention of children's accidents.

Pp.20-21: Cuts. Includes: Accidents from glass (French windows); a toddler carrying a mug or glass tumbler; children getting hold of a sewing kit, sharp tools. Also gives instructions on what to do in an emergency.

* King, M., King, F., and Martodipoero, S. (1978) Primary child care, a manual for health workers. Book 1.
Includes many useful sections including: p.146. closing a cut with adhesive tape.

CLOSING A CUT WITH ADHESIVE TAPE

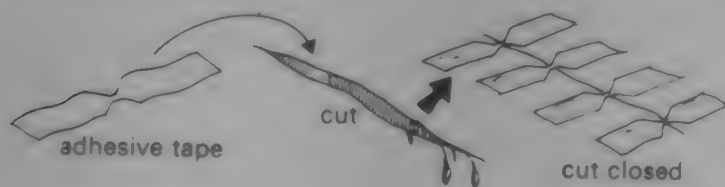
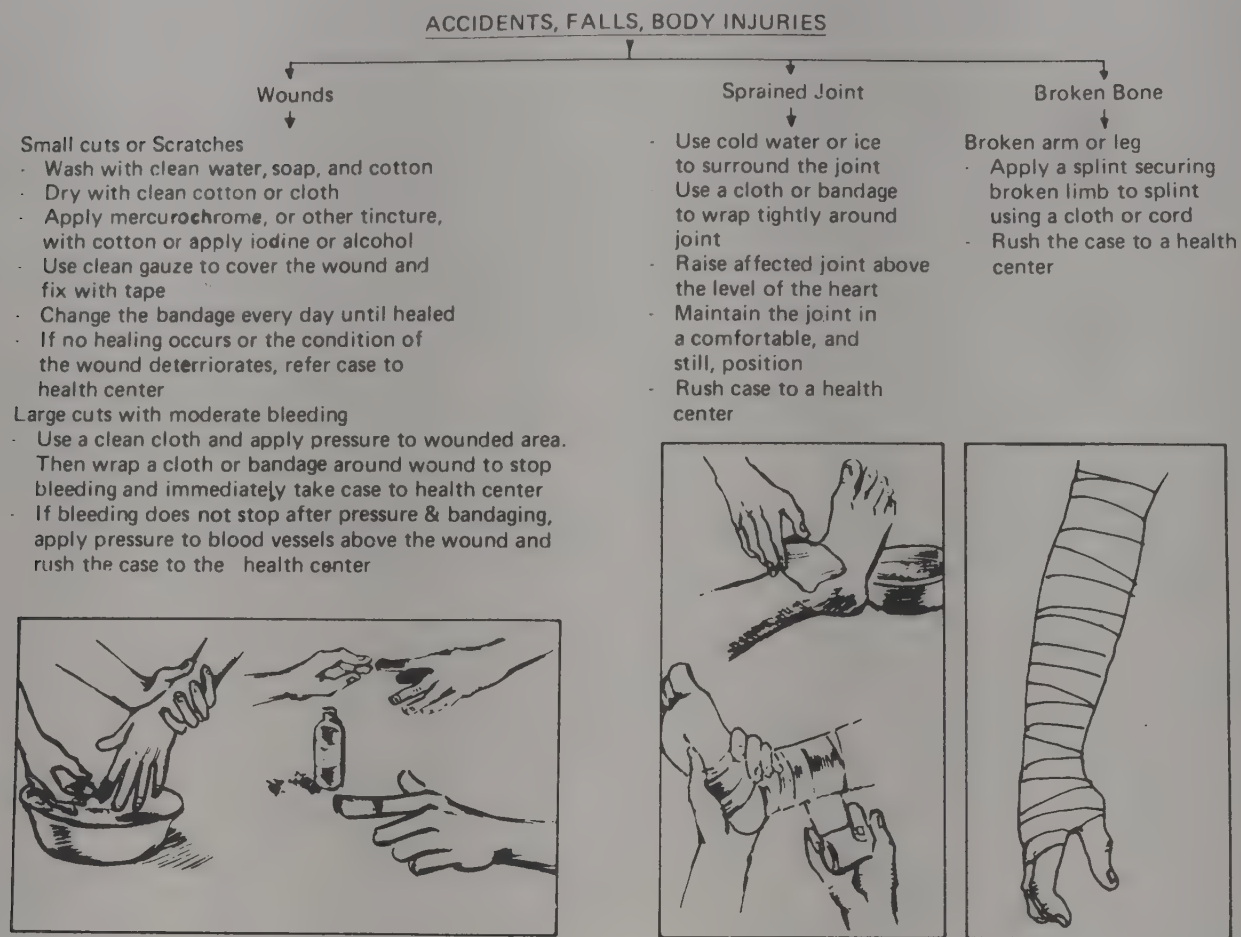


Fig. 14-4 How to stitch up a cut.

Fig. 8.6.

* New Zealand, Dept. of Health (1956) Check your home for safety. Pamphlet No.68. (Health reprint). Mimeo also.
Contains a useful checklist of action to be taken to avoid falls, e.g. wipe up spilt grease or liquid.

* Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work mannuals. Vols. I-IV.



Werner, D. (1977) Where there is no doctor.

"Cuts, scrapes and small wounds

Cleanliness is of first importance in preventing infection and helping wounds to heal.

To treat a wound

First, wash your hands very well with soap and water.

Then wash the wound well with soap and boiled water.



When cleaning the wound, be careful to clean out all the dirt. Lift up and clean under any flaps of skin. You can use clean tweezers or other instruments to remove bits of dirt, but always boil them first to be sure they are sterile.



If possible, squirt out the wound with boiled water in a syringe or suction bulb.



Fig. 8.9

Any dirt that is left in a wound can cause an infection.

Never put animal or human faeces or mud on a wound. These can cause dangerous infections, such as tetanus.

Never put alcohol, tincture of iodine, or Merthiolate directly into a wound; doing so will only damage the flesh and make healing slower. Use soap and water.

Large cuts: How to close them

A recent cut that is very clean will heal faster if you bring the edges together so the cut stays closed.

Close a deep cut only if all of the following are true:

the cut is less than 12 hours old

the cut is very clean, and

it is impossible to get a health worker to close it the same day.

Before closing the cut, wash it very well with boiled water and soap. If possible, squirt it out with a syringe and water. Be absolutely sure that no dirt is left hidden in the cut"

'BUTTERFLY' BANDAGES OF ADHESIVE TAPE

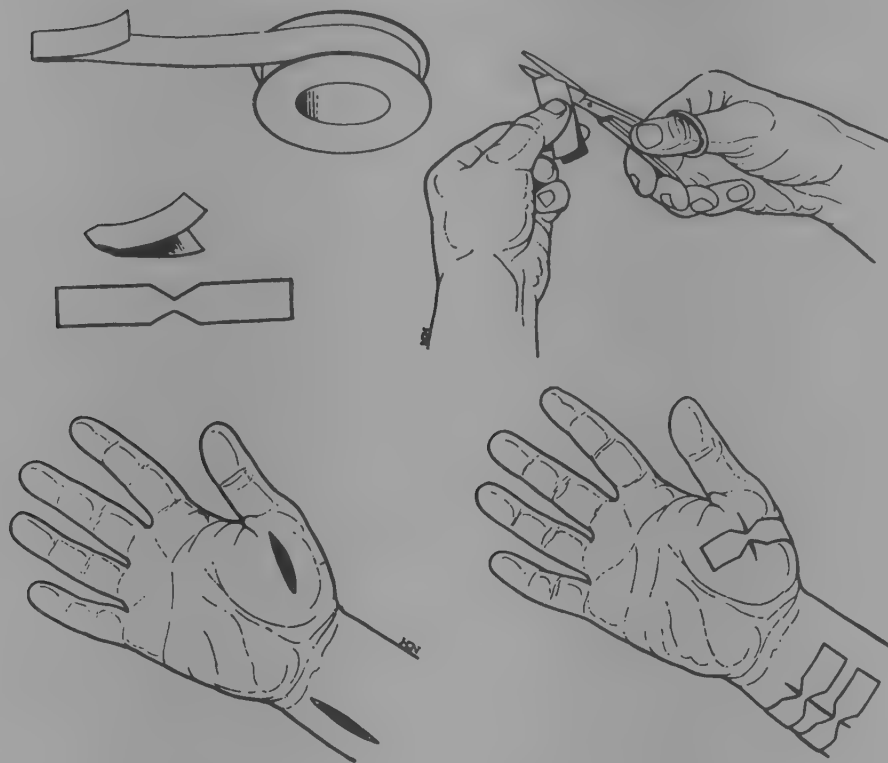


Fig. 8.10

"There are two methods to close a cut:

1. Bandages. Bandages are used to help keep wounds clean. For this reason, bandages or pieces of cloth used to cover wounds must always be clean themselves. Cloth used for bandages should be washed and then dried with an iron or in the sun, in a clean, dust-free place. If possible, cover the wound with a sterile gauze pad before bandaging. These pads are often sold in sealed envelopes in pharmacies. Or prepare your own sterile gauze or cloth. Wrap it in thick paper, seal it with tape, and bake it for 20 minutes in an oven. Putting a pan of water in the oven under the cloth will keep it from charring.

It is better to have no bandage at all than one that is dirty or wet.

If a bandage gets wet or dirt gets under it, take the bandage off, wash the cut again, and put on a clean bandage.

This block contains 12 line drawings arranged in three rows, illustrating various first aid techniques:

- Row 1:**
 - Top left: A hand is being bandaged with a roll of material.
 - Top middle: A hand is being bandaged with a roll of material.
 - Top right: A hand is being bandaged with a roll of material.
- Row 2:**
 - Middle left: A hand is being bandaged with a roll of material.
 - Middle middle: A hand is being bandaged with a roll of material.
 - Middle right: A hand is being bandaged with a roll of material.
- Row 3:**
 - Bottom left: A person's head is wrapped in a bandage.
 - Bottom middle: A person's head is wrapped in a bandage.
 - Bottom right: A person's arm is wrapped in a bandage.

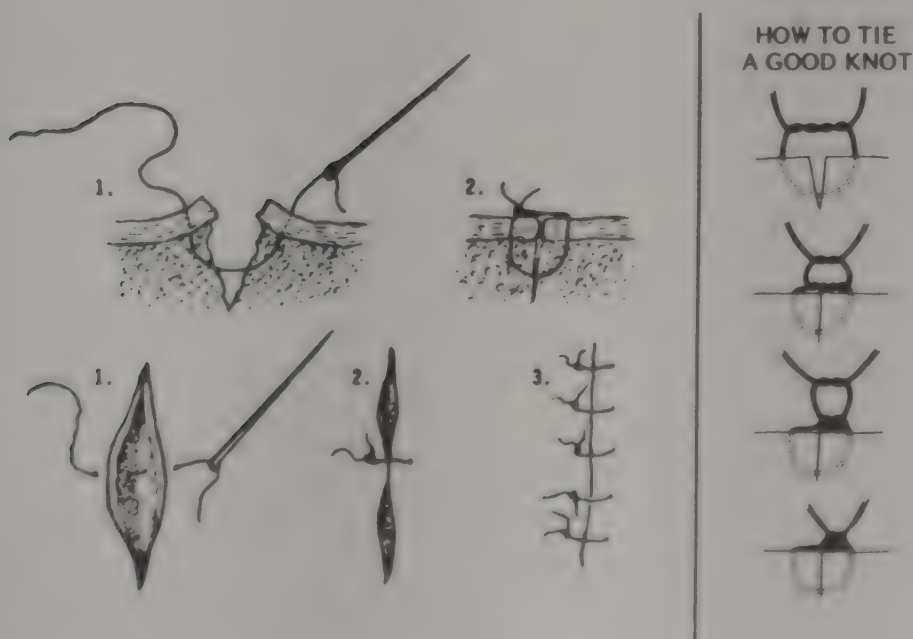
Caution: Be careful that a bandage that goes around a limb is not so tight it cuts off the flow of blood.

Many small scrapes and cuts do not need bandages. They heal best if washed with soap and water and left open to the air. The most important thing is to keep them clean.

To find out if a cut needs stitches, see if the edges of the skin come together by themselves. If they do, usually no stitches are needed.

Boil a sewing needle and a thin thread (nylon or silk is best) for 10 minutes.

Sew the wound like this:



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Make the first stitch in the middle of the cut, and tie it closed (1. and 2.).

Make enough stitches to close the whole cut (3).

Leave the stitches in place for 6 to 12 days (on the face 6 days; the body 8 days, the hand or foot 12 days). Then remove the stitches; cut the thread on one side of the knot and pull the knot until the thread comes out...

If the wound that has been closed shows any signs of infection, remove the stitches immediately and leave the wound open.

* Wyatt, G.B., and Wyatt, J.L. (1973) Medical assistant's manual - a guide to diagnosis and treatment.
Chapter 31 of this book deals with injuries, wounds, haemorrhage, burns, scalds, shock etc. The different kinds of wounds (bruise, laceration, abrasion, incision and stab) are well illustrated with line diagrams. Stitching, and plaster bandages are also shown.

9. Help with handicap and disability for children and mothers.



9. Help with handicap and disability for children and mothers.

9.1

The problem of disability

Development and Cooperation (1981) One person in ten is disabled. No.3.

New Internationalist (1981) The disabling world. Special issue for International Year of Disabled Persons. No.95.

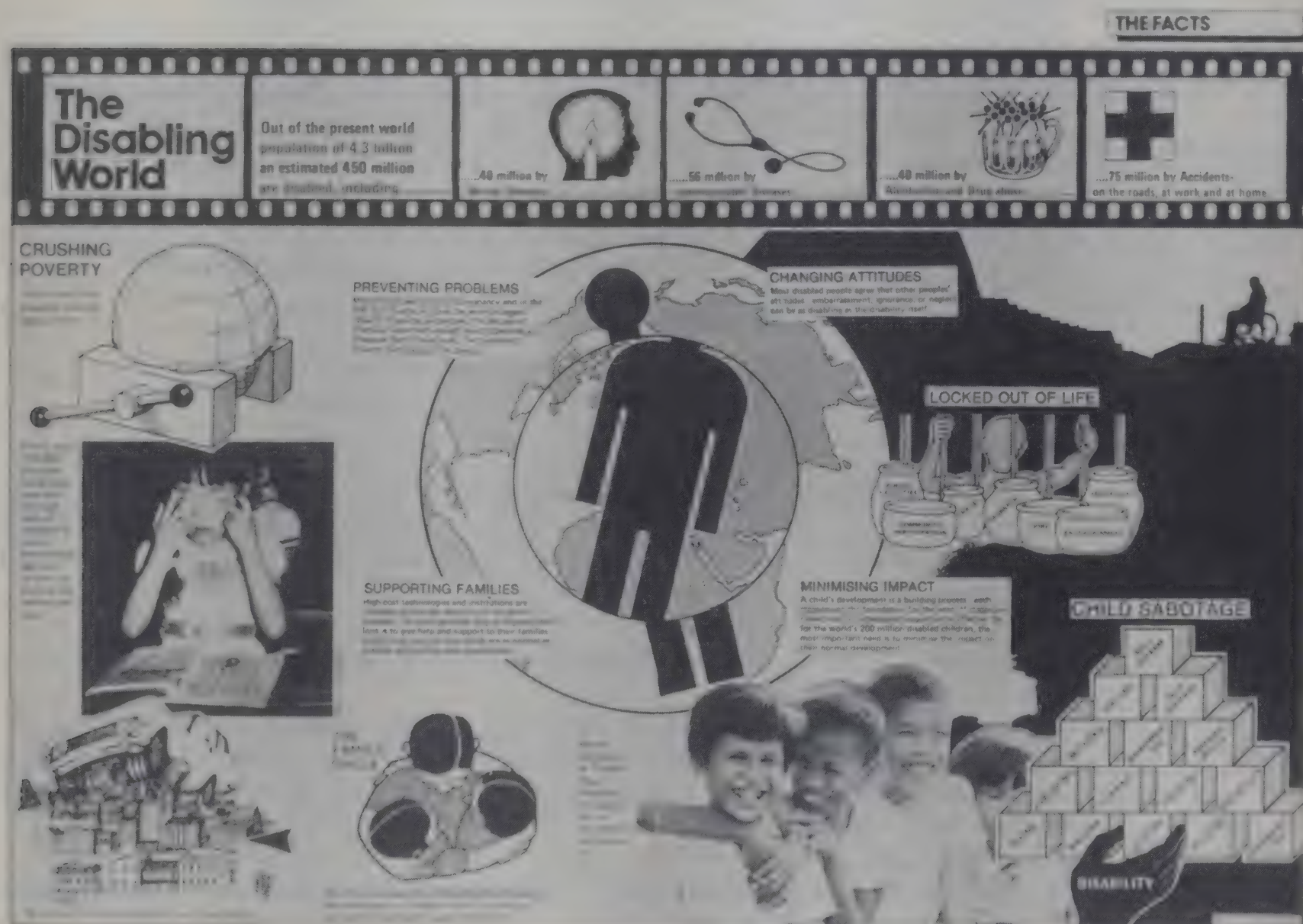


Fig. 9.1.

* Oxfam (1981) One in ten, disability and the very poor, by Adrian Moyes. 33pp.

9.2.

General sources on coping with a disability

* Hart, D. and Walters, J. (1979) One of the family, a booklet for brothers and sisters of children with handicaps. "Well, you get people who stare and you get people who come up to you and give you 10p in your hand. But the best thing to do if

people stare at you is just ignore them."

This small useful booklet gives advice to family members, especially brothers and sisters, on how to cope with the situation when they have a brother or sister with a handicap. It can be used by friends, neighbours, or any person interested in helping children with handicaps. The booklet tries to answer some questions that are often asked: What is handicap? How to help at home? What causes handicap? Who will look after a child with a handicap? What to do at school and after school? It is illustrated with photographs.

* Helander, E., Mendis, P., and Nelson, G. (1983) Training disabled people in the community: a manual on community-based rehabilitation for developing countries. RHB/83.1

Very useful. Organised in six main booklets, each containing a number of training components. Most of the booklets focus first on breastfeeding; then on normal child development; then social activities; then the daily tasks of rural women; and then job placement. In each booklet these stages are related to coping with a specific disability. The disabilities focused on are:

1. Persons who have fits;
2. Persons who have difficulty with hearing and/or speech,
3. Persons who have difficulty with learning;
4. Persons who have difficulty with moving;
5. Persons who have difficulty with seeing;
6. Persons who show strange behaviour.

* International Children's Centre (1981) Screening and social integration of handicapped children. Leaflets for academic level workers; nurses, midwives, social workers, teachers and parents; and mass media specialists. Eng. Fr. Sp.

* Oxfam (1981) One in ten, disability and the very poor, by Adrian Moyes. 33pp.

A very useful comprehensive booklet. The topics include: the world causes of disability; rehabilitation at home; locally made aids; blind farmers; village integration; do it yourself manuals; Oxfam back-up services.

* United Nations, JUNC/NCO Sub-group on Women and Development (1981) Women and disability.

A folder of materials designed to help show the link between poverty and disability, and the status of women and disability. Sections include: "We live in a disabling world", "The second class disabled", "Prevention and rehabilitation".

9.3.

Help for the child with a mental handicap

Bicknell, J. (1980) Mental handicap.

These 48 slides are based on the situation in Britain but could be relevant to other countries as well. They are addressed to medical students and non-specialist doctors. Slides 1-2 deal with introduction and classification; slides 3-27 cover inherited abnormalities (chromosome disorders, inborn errors of metabolism); slides 28-41 show multiple or uncertain causes (hydrocephalus,

meningomyelocoele); slides 44-48 deal with acquired conditions (prenatal, perinatal, postnatal).

Centre technique national d'etudes et de recherches sur les handicaps et les inadaptations (CTNERHI) Fr.

1. 28 publications: e.g. L'enfant sourd avant 3 ans - enjeu et embuches de l'education precole; Scolarisation et insertion sociale de l'enfant epileptique.
2. Quarterly bulletin reviewing new information.
3. Monthly review, Handicaps et inadaptations, les cahiers de CTNERHI.

Deschamps, J.P., Manciaux, M., Salbreux, R., Vetter, J. and Zucman, E. (?1981) L'enfant handicape et l'ecole. Fr.

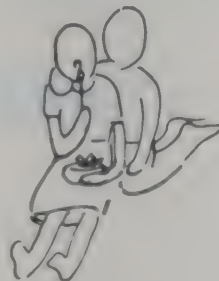
* Helander, E., Mendis, P. and Nelson, G. (1980) Training the disabled in the community, an experimental manual on rehabilitation and disability prevention for developing countries. DPR/80.1. Rev 2.

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The disabilities focused on are:

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2. Persons who have difficulty with hearing and/or speech;
3. Persons who have difficulty with learning;
4. Persons who have difficulty with moving;
5. Persons who have difficulty with seeing;
6. Persons who show strange behaviour.

- Sit or stand on one side of the person and place your hand behind the person's neck to support the head.



- Or you could make a collar like this out of cardboard.

Wrap the collar in a piece of cloth and tie it round the person's neck to support the head like this.



- You should train the person to sit against the wall.

Train the person to keep the legs in a position that he/she finds comfortable.



- The person should also do activities in this position. If it is difficult to do activities in this position, he/she could support himself/herself on one arm.



If the person cannot sit supported against the wall, you should train him/her to do so in the following way:

- Ask him/her to sit in this position while you push him/her gently forwards and backwards, and from side to side.

You can tell the person to keep the eyes open at first because this will help him/her to keep the balance.



When the person can do this easily, you can ask him/her to close the eyes and then repeat the same exercises.

Do not let the person fall.

Push the person 10 times in each direction.



- Next teach the person to sit supporting himself/herself on arms, away from the wall.



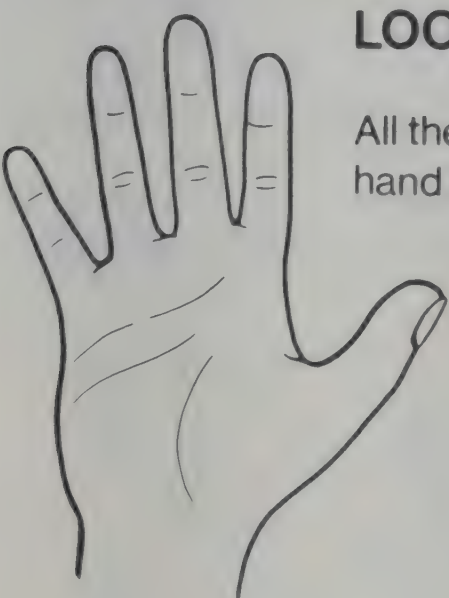
Fig. 9.2.

India, Post Graduate Medical Institute, Chandigarh (?1981)
Recognition and management of mentally handicapped children.
18pp.

A useful booklet, simply written and well illustrated. It starts with asking "What is mental handicap?" and replies by pointing out that all the fingers of the hand are not the same and that people differ in the size, shape and colour: similarly some of us have more mental abilities, some less. "Do you know an average village of 1000 has 10-15 mentally retarded children?" Common causes are listed. Mental handicap is recognised from delayed milestones, school problems (illustrated), poor social development. Guidelines for home care emphasise repetition and encouragement,

rewarding a desired activity, converting activity into play, teaching in stages, doing things together with the child and teaching with love and affection. Community care can include: learning simple household activities, helping in agricultural activities, learning simple trades. Prevention is aided by adequate MCH care, immunisation, breastfeeding babies. The booklet also includes a page on misconceptions: drugs cannot cure mental handicap, traditional healers cannot solve the problem, marriage is no "cure".

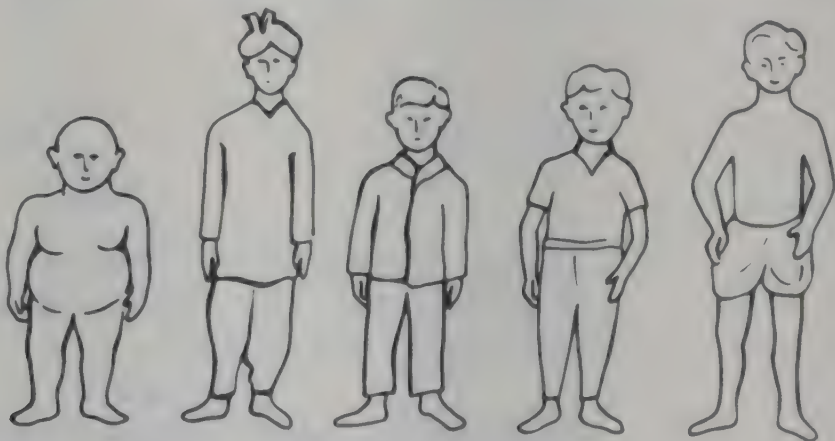
WHAT IS MENTAL HANDICAP ?



LOOK !

All the fingers of the hand are not similar

People differ in their size, shape and colour



GUIDELINES FOR HOMECARE



Teaching with love and affection



Repetition and Encouragement

Rewarding desired activity

Convert activity to play

Teaching in steps

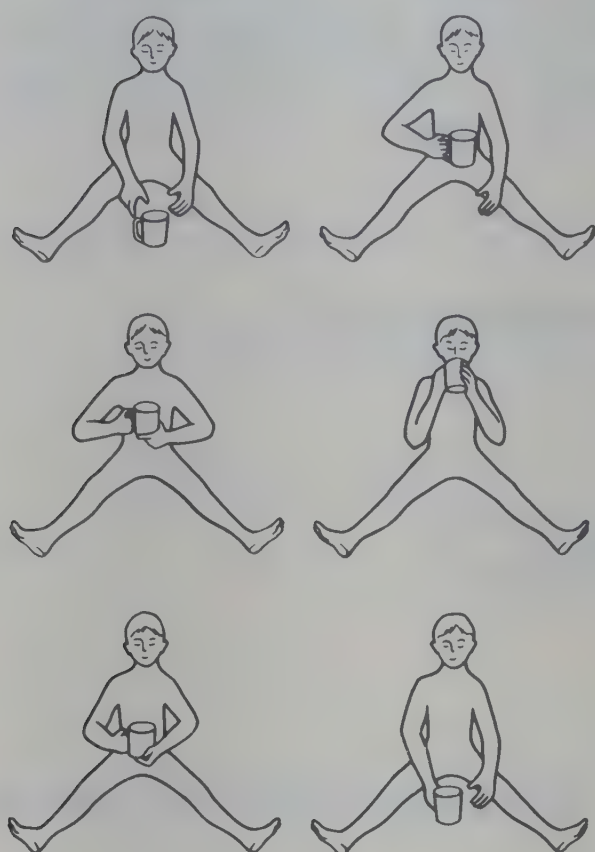
Do things together with the child

Fig. 9.3.

GUIDELINES FOR HOMECARE

Teaching social skills in steps - Examples

To drink water



To take bath



Fig. 9.4.

India, Directorate General of Health Services (1979) National planning for the mentally handicapped. 217pp. Reference material.

Indonesia, Directorate General of Community Health (1976) Health centre reference manual. Vol. III: Section II Mental health.

Mental retardation. Includes a table of guidelines on symptoms and care and management by health centre staff.

* **MENCAP, UK.**

Many useful publications and help for parents.

* **Swift, C.R. (no date)** Mental health.

Chapter 17: Mental subnormality.

P.68: Problems of children with a mental handicap.

* **Wig, N.N. and Srinivasa Murthy, R. (1981)** A manual of mental disorders for primary health care personnel. Includes a section on mental retardation. Useful for reference.

9.4.

Help for the child with a physical handicap

* **AHRTAG (Appropriate Health Resources and Technologies Action Group).** London. An organisation with special interest in disability, prevention and rehabilitation. New materials are being produced.

* AHRTAG (1984) Personal transport for disabled people: design and manufacture.

A practical manual which describes how to make cheap and effective transport aids locally.

* Caston, D. (1981) How to make handgrips. A poster which folds into a booklet.

Explains how handgrips can help disabled people hold tools and brushes etc.

* Caston, D. (1982) Low cost physiotherapy aids. 45pp. Excellent line drawings of simple aids for exercising different parts of the body. All the aids are designed to use local materials and skills. They need wood or bamboo, nails, string and cloth. The tools needed are a saw, chisel, hammer and a drill. Includes exercises for fingers, hand, wrist and arm, arm and shoulder, arm and leg, leg, arm, foot, body raising.

* Caston, D. (1982) Low cost aids. More excellent line drawings.



Fig. 9.5.



Fig. 9.6. Aids for the disabled.

"Children learn through play. Handicapped children can learn to do many things for themselves and be important members of the community.

The playground can be part of the village. The aids should be put in the shade of the trees.

These aids have been in use for five years. They are simple to

make and cost nothing. Both handicapped and normal children can play together.

All you need to make the aids is a knife, a hammer and string".

* Caston, D. (?1981) Playing together, aids for disabled children. A set of 8 pop up illustrations plus instruction sheet.

Disabled living foundation, UK.

Over 250 books and information papers offering practical ideas on eating and drinking aids; clothing adaptations; walking, transport and communication aids. Also provides information for those with a specific disability e.g. cerebral palsy, paralysis.

Eshuis, J. and Monschot, P. (1978) Communicable diseases.

P.318 ff: "Physiotherapy: Joints which are not used will become stiff. Scar tissue tends to retract resulting in contractures. Muscles which are not used will shrink and result in muscle atrophy. All patients with weak or damaged hands and feet, or weak eyelids, should do suitable exercises.

Check each patient to see if he has normal ranges of motion.

Exercises are of benefit in the following ways:

1. Exercises can prevent loss of the normal range of motion and prevent stiffness. Stiffness may cause the patient to injure himself and do further damage.
2. Exercises can stop further stiffness.
3. Exercises can improve or help to restore normal ranges of motion, can help to strengthen weak muscles, and can help muscles to function more effectively.

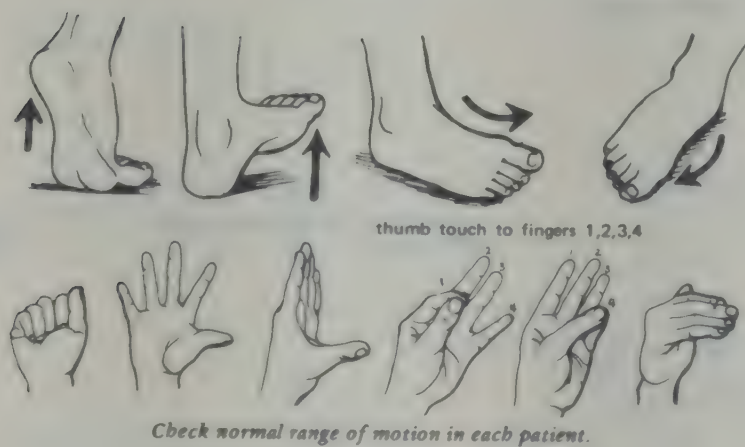


Fig. 9.7.

There are two types of exercises: passive and active.

Passive exercises are done with the other hand or by another person. They are useful because they can lengthen ligaments and thus loosen stiff joints and can lengthen skin and muscles.

Patients should do passively whichever normal motion they cannot do actively".

* Helander, E., Mendis, P. and Nelson, G. (1980) Training the disabled in the community; an experimental manual on rehabilitation and disability prevention for developing countries. DPR/80.1. Rev 2.
Full of useful ideas. See the annotation in Section 9.2.

* Hesperian Foundation (1984) Project Projimo, a village run rehabilitation program for disabled children in Western Mexico.

* Huckstep, R.L. (1975) Poliomyelitis, a guide for developing countries, including appliances and rehabilitation for the disabled.
Useful at district level rather than at local community level.

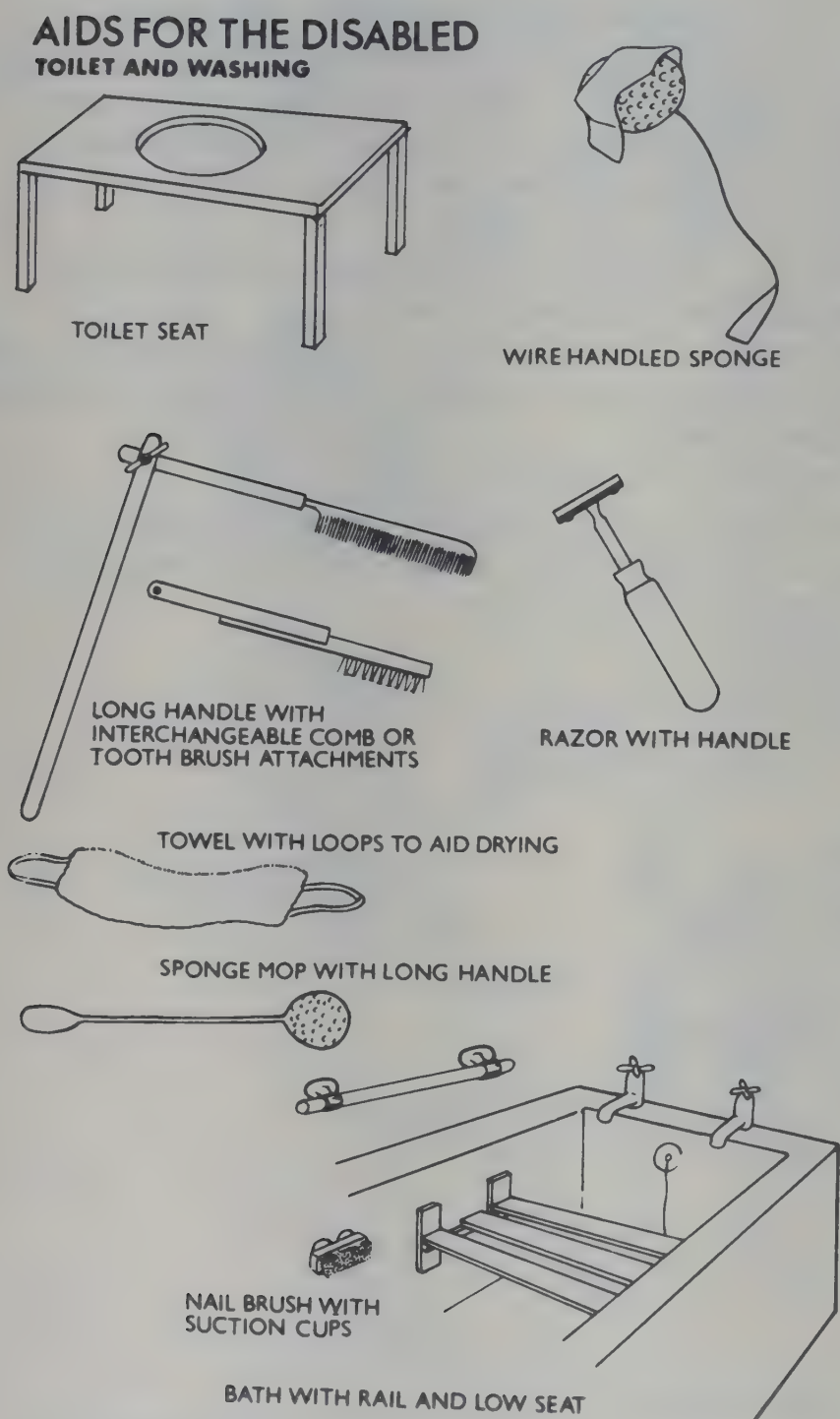


Fig. 9.8.

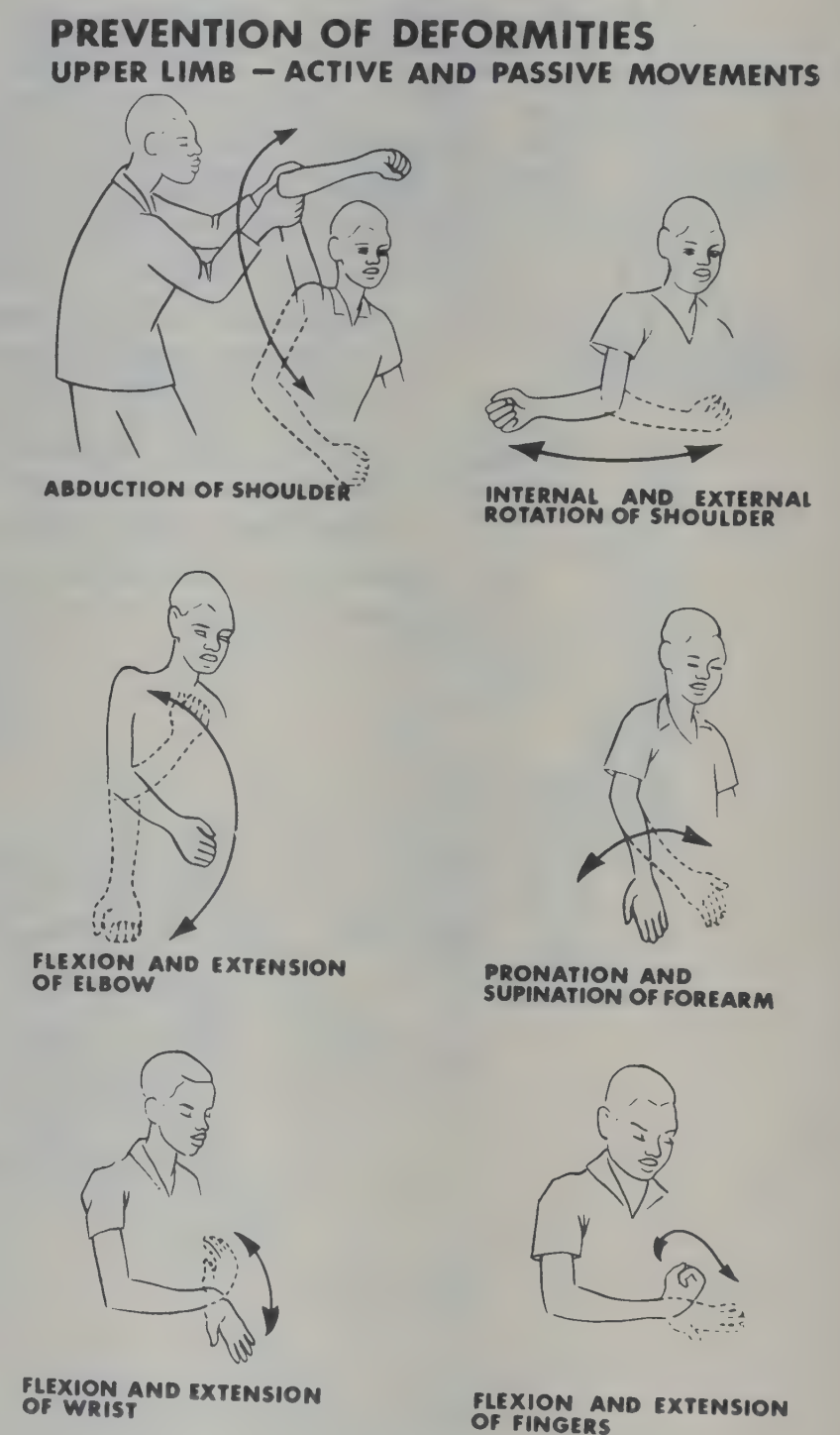


Fig. 9.9.

CAUSATION OF DEFORMITIES IMBALANCE OF MUSCLES

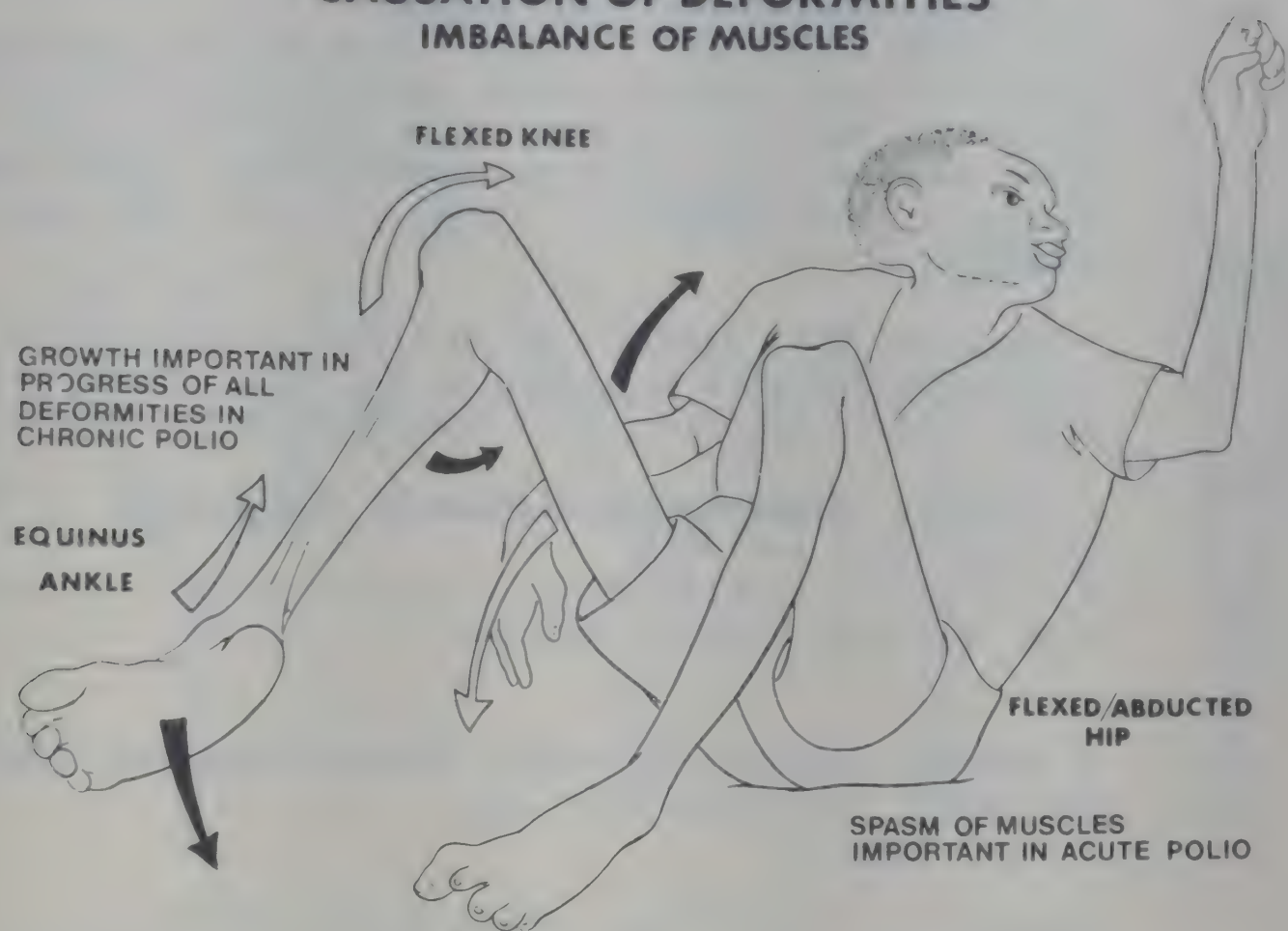


Fig. 9.10.

CAUSATION OF DEFORMITIES IMBALANCE OF MUSCLES

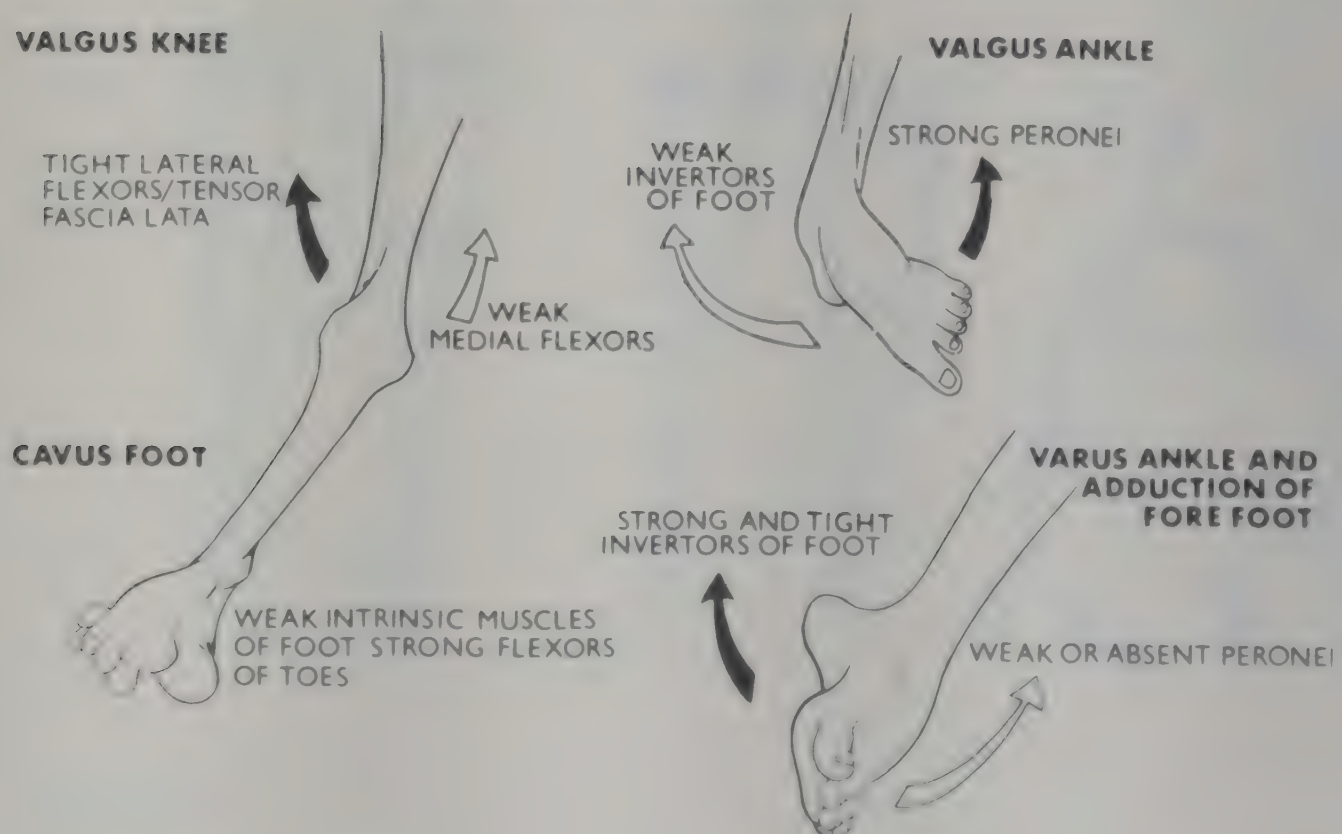


Fig. 9.11.

* **International Children's Centre** (1981) The motor disabled children. Children in the Tropics No.131. Useful for reference. Includes: play and the disabled child; school and the disabled child; associations of parents of disabled children. Reproduces a booklet on "Training in sitting up from a prone position and remaining seated alone". from Helander, E., Mendis, P. and Nelson, G. (1980) Training the disabled in the community.

* **McLaren, P.A.** (1979) Occupational therapy as part of a primary health care programme in Kwa Zulu. Paper presented to the South African Association of Occupational Therapists. Mimeo.

* **Nigeria, Nigerian Association of Paraplegics** (1981) Looking after yourself. A very useful booklet written in the form of a few suggestions for self care for disabled persons.

* **Uganda, Ministry of Health, Health Education Division** (no date) Poliomyelitis. 7pp. A short booklet.

Werner, D. (1977) Where there is no doctor. Pp.314,315: Illustrates 2 parallel poles supported on 4 forked sticks for a child to learn to walk, and a series of 11 drawings demonstrating how to make simple crutches.

HOW TO MAKE SIMPLE CRUTCHES

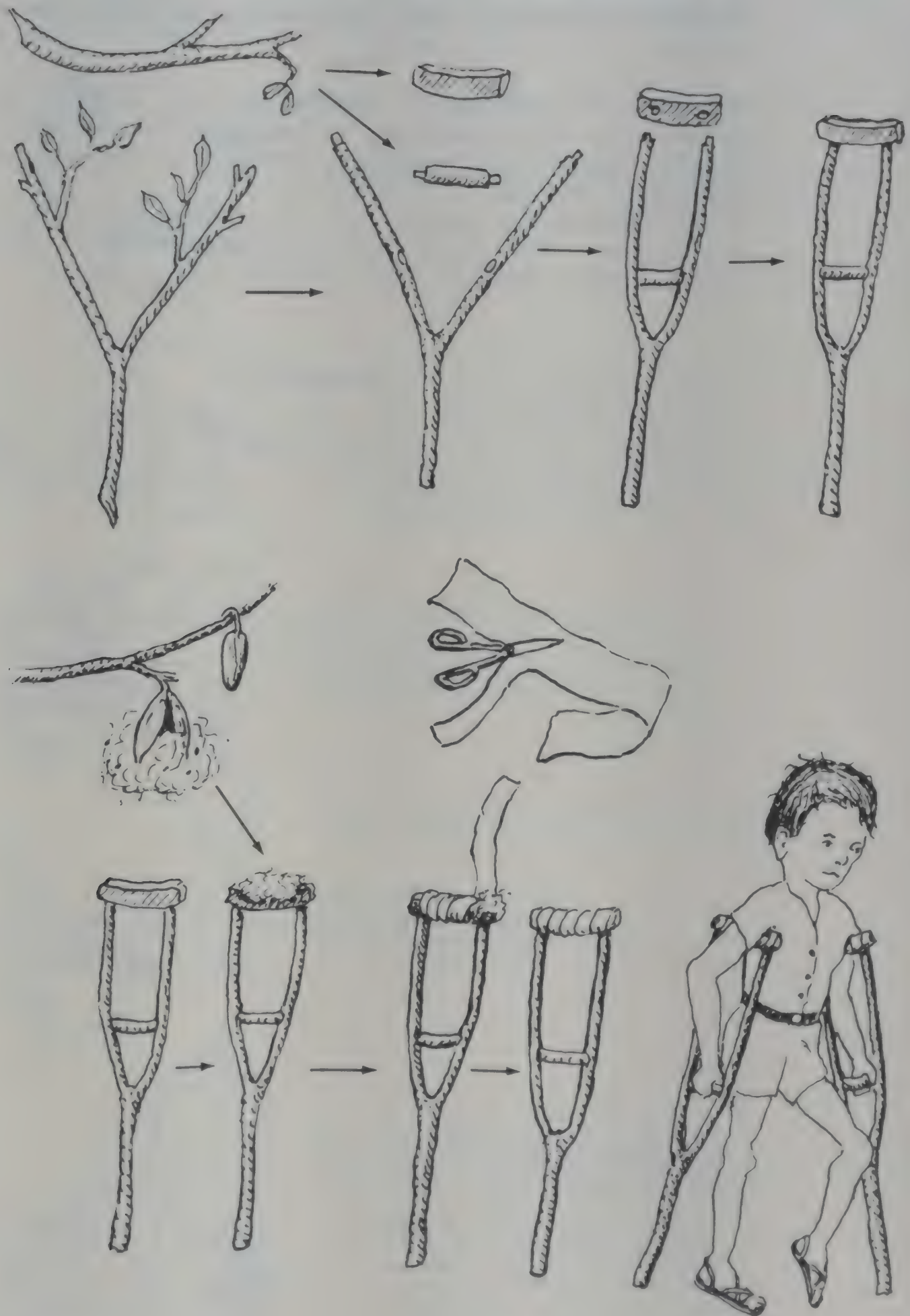


Fig. 9.12.

Help for the mother with a disability

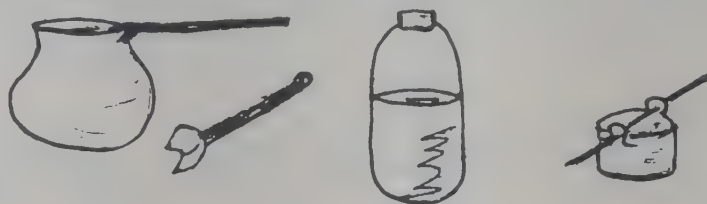
*** Disabled Living Foundation, UK.**

Supplies information and practical help with aids to help daily living.

Helander, E., Mendis, P. and Nelson, G. (1980) Training the disabled in the community, an experimental manual on rehabilitation and disability prevention for developing countries. DPR/80.1. Rev 2.

A key element for rural women is learning to cope with daily activities. This gives many practical ideas on water carrying, using a yoke, wheelbarrow, trolley etc.

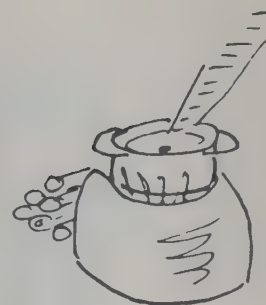
- Pots should have handles to make it easier for the woman to lift them. The handles will protect her hands from burns.



- She must use spoons with long handles so that she does not have to bend too close to the fire. Long handles can also be fixed on the lids.



- If metal pots are used, a small stone placed in the pot will make a sound when the water in the pot boils.



- To help the person you are training to be able to pour an exact amount of water or other liquid, you could use a "level-stop" like this.

The bottle from which the water is being poured should have a tight-fitting stopper. You can make the stopper out of cork.

Make two holes in the stopper and put two pieces of cane or bamboo through it like this. See that one tube is shorter than the other.

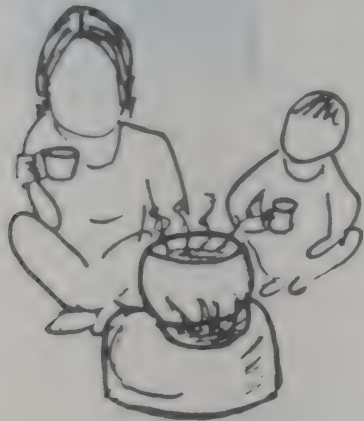
Now the person pours the water out. When the level reaches that of the shorter tube, no more water will pour out of the bottle.



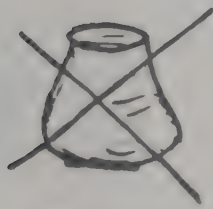
Fig. 9.13.

FETCHING WATER

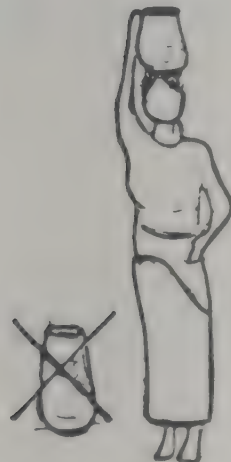
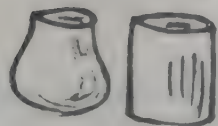
You must make sure that the water is collected from a clean source. If this is not possible, talk to your community leaders about the possibility of finding another source such as digging a well.



- Teach the woman that any water used for drinking should be boiled to prevent diseases.



- Buckets and drums used for carrying water should not be heavy because it adds unnecessarily to the load



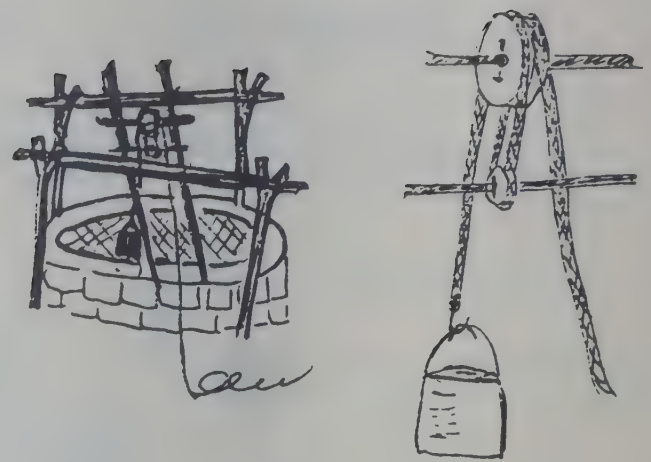
- If the source of water is nearby, a little water could be carried at a time.



- Water pumps should have long handles. Then it is easier to pump the water.

Fig. 9.14

- If water has to be drawn from a well, use two pulleys in this way. It will make it easier to pull the water up.

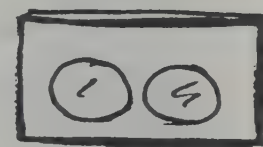


- If the woman has to go a long way to fetch water, you can make a trolley for her on which she can place the bucket of water. She can then pull the trolley along.

The buckets should be fixed to the trolley so that they do not move.



- The buckets can be kept in place by using a piece of wood with holes cut in like this. The piece of wood is placed inside the trolley and the buckets placed in the holes.



- Or you can make her a wheelbarrow on which she can place the bucket of water.



- If the woman has difficulty in lifting the heavy bucket of water, you can do the following: Make a yoke with a pole on which two buckets of water can be fixed at the ends. The woman can lift the yoke up with, and carry it on, her shoulders.

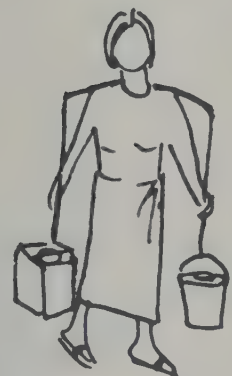


Fig. 9.15.

Notes

Notes

10. Planning, organisation and evaluation of MCH care.



10.

Planning, organisation and evaluation of MCH care.

10.1.

Community diagnosis of health problems, causes of ill health and health care resources

Finding out about child nutrition in the community, see Section 2.1. of this bibliography.

Finding out about the community's needs for birth spacing/family planning services, See Section 4.3.1. of this bibliography.

* Abramson, J.H. (1979) Survey methods in community medicine. Useful for senior workers.

* Allman, J. and Pierre-Louis, M.B. (1982) Carrying out a survey on attitudes to diarrhoea. Diarrhoea Dialogue, No.9: pp.6-7.

Provides a useful list of questions to ask, developed from a study in Haiti.

* AHEA (American Home Economics Association) (1977) Working with villagers. Trainer's manual, prototype lessons, media resource book.
Training Unit IV: "Getting to know the villagers and the village".

* Barker, D.J.P. (1976) Practical epidemiology. Useful for senior workers.

Bennet, A.E. and Ritchie, K. (1975) Questionnaires in medicine: a guide to their design and use.

* Bennet, F.J. (ed.) (1979) Community diagnosis and health action; a manual for tropical and rural areas. Useful for senior workers.

* Canadian Public Health Association (1980) Guide to questionnaire construction and question writing. Useful for senior workers.

Centre for World Development Education (1979) The development puzzle, a source book for teaching about the rich world/poor world divide and one world development efforts.

* CHILD-to-child Programme (1979) Activity sheets: Health scouts.

An activity sheet for finding out about the health problems of children in the community and the health services available.

* CHILD-to-child Programme (1979) Activity sheets: Our babies growing up.

An activity sheet for school children, recording births and monitoring the progress of growth.

* **CHILD-to-child Programme** (1979) Activity sheets: Our neighbourhood, making it better.
An activity sheet for drawing a health map of our village. Where are the dangers? What can we do to prevent accidents and disease?

* **Colgate, S.H. et al** (1979) The nurse and community health in Africa.
Chapter 1: Steps in the systematic study of a community; planning the study; data collection, including factors that influence health, socioeconomic, cultural, political, environmental; analysis and interpretation of the information collected. Very useful.

Dorozynski, A. (1975) Doctors and healers. IDRC-043e.
Recognises the shortcomings of dependence on doctors alone.

* **Fuglesang, A.** (1982) About understanding-ideas and observations on cross cultural communication. 231pp.
Asks what is a community? Contains useful diagrams of communication flows.

Ghana, Ashanti-Akim District Profile (1978) Who needs maternity care? Reprinted In Amonoo-Lartson, R. et al: (1984) District health care. Challenges for planning, organisation and evaluation in developing countries.

Haslemere Group (no date) Who needs the drug companies? This booklet describes the malpractices of some of the drug companies and the implications for health care, particularly in the "third world".

* **Heller, T. and Elliott, C. (ed.)** (1977) Health care and society; readings in health care delivery and development.

* **Hoinville, G. et al.** (1977) Survey research practice. Useful for senior workers.

* **Huff, D.** (1973) How to lie with statistics.
A short, useful book with amusing illustrations.

International Children's Centre (1980) Child abuse and neglect. Leaflets. Eng. Fr. Sp.
Useful documents for nurses, midwives, social workers, teachers and parents; policy makers and mass media specialists.

IDRC (?quarterly) IDRC Reports. Newsletter.
Often has material relevant to community diagnosis e.g. October 1981 10 (3), Indexing buffaloes.

IDRC (1975 - 1982+) **SALUS**: Low cost rural health care and health manpower training, an annotated bibliography with special emphasis on developing countries. Vols. 1-7. Abstracts in Eng. Fr. Sp.
Useful for identifying work done in a particular area or topic.

ILO (1979) Man in his working environment, a workers' education manual.

Raises questions on the working environment in both rural and urban areas, with a useful section on topics for discussion at the end of each chapter.

ILO (1979) Profiles of rural poverty.

Irvine, H., Mills, I. and Evans, J. (eds.) (1979) Demystifying social statistics.

Useful for senior workers.

* King, M., King, F., Morley, D., Burgess, L. and Burgess, H. (1972) Nutrition for developing countries; with special reference to the maize, cassava and millet areas of Africa. Diagnosis of a community's nutrition problems (Section 9.24).

* Lesotho, RHDP and MOH (1982) Health problems in the community using drawings to start a discussion. A booklet designed to help anyone working in the community to find out what people think about their health problems. Part of a set of community education materials being field tested. Includes useful questions to start a discussion.

* McCusker, J. (1978) Epidemiology in community health. A self-teaching manual for rural health workers.

* Mabry, E.G. (1972) Planning a community health programme. 56pp.

Useful ideas presented in a compact booklet, including some broad questions intended to find out health problems, and the factors related to them, such as overcrowding, poor nutrition, inadequate medical care.

Manciaux, M. (1981) Children of disadvantaged families.

Marana, M.R.V. (1980) An introduction to acupuncture. A primary health care handbook.

Oppenheim, A.N. (1968) Questionnaire design and attitude measurement.

For senior workers.

Oxfam (1976) The doctor-go-round. Health care in Britain and the developing world: medical manpower, migration and aid. Part 1 reviews some aspects of health care in the developing world, including medical training, migration flows and the key role of auxiliaries. Given the enormity of the supply/demand gap, it points out that the health care needs cannot be met by any imaginable increase in the provision of doctor-services, in view of the prohibitive costs. The case is therefore argued for a much greater concentration of available health resources on the provision of rural health schemes, using a full range of auxiliary staff to provide the outreach for small teams of fully qualified personnel in regional and national centres. Part 2 examines British medical manpower policy and, in particular, the use of doctors from developing countries in health services. It questions continuing dependence on the latter source, given that their future availability is increasingly unsure. And it

concludes that help should be given to the poor countries to retain their doctors rather than giving them preferential work permits in richer countries.

*** Oxfam (?1980) The poverty game.**

A board game which aims to give an understanding of the vulnerability of the subsistence farmer to chance events; the difficulty of taking decisions in this precarious situation; and the vicious spiral of misfortune, poverty, malnutrition and disease. Materials for the game include: crop cards setting out the yields of each crop; disaster cards; help cards; disease cards; a weather dice and an ordinary dice.

Paul, B.D. (1955) Health, culture and community: Case studies of public reactions to health programmes.

An old book but it is still useful.

*** Peace Corps (1978) Community health education in developing countries. Manual M-8.**

This bulky manual is one of a series of "Appropriate Technologies for Development" manuals developed by the Peace Corps Information Collection and Exchange. It covers ways of setting up a community health project, with the steps explained in each chapter. Chapter 1 deals with "knowing the community" and Chapter 2 deals with "community organisation". In Chapter 4, there is a case study and exercise in project planning from Thailand.

Pearson, P. and Rowan, J. (1981) Human inquiry: a source book for new paradigm research.

An important book on the interaction between those who try to find out through interviews and those who are interviewed. However, it is technically written, so is suitable for senior people only.

*** Philippines, AKAP (?1982) Learning and teaching about medicinal plants.** A: Gathering information; identifying plants; making a plant album; making your own community herbal. T: Preparing medicinal plants (poultices, simple extracts, oils, starches, powders, decoctions, infusions, tinctures, syrups, preserving syrups). S: Collecting and storing medicinal plants (collecting time, conservation, sorting, slicing, blanching, sun drying, air drying, oven drying, storage). R: Plant propagation (starting a community garden, getting information, collecting seeds for planting, drying and storing seeds for planting, planting seeds, cuttings). E: Use of medicinal plants for various problems (guidelines for teaching).

An excellent series of line illustrated leaflets with simple captions.

Philippines, Luzon Secretariat of Social Action (1978)

Philippine medicinal plants in common use, their phytochemistry and pharmacology a community based health programmes handbook, by Michael L. Tan.

Useful example of the sort of booklet that could be developed for other countries.

*** Philippines, Rural Missionaries (1976) Go to the people,**

Short, covering basic ideas. Not really appropriate for practical surveying.

* Scotney, N. (1976) Health education; a manual for medical assistants and other rural health workers. 141pp.
Pp.77-84. How people begin to recognise informal, political, professional and voluntary leadership (with good examples of relevance for nutrition teaching. Pp.28-35: The special health problems and health service needs of many rural areas.

Sholinsky, J. (1974) Map skills book.

Although intended for school children this contains many useful ideas for teaching map skills to anyone, including health workers doing a community diagnosis.

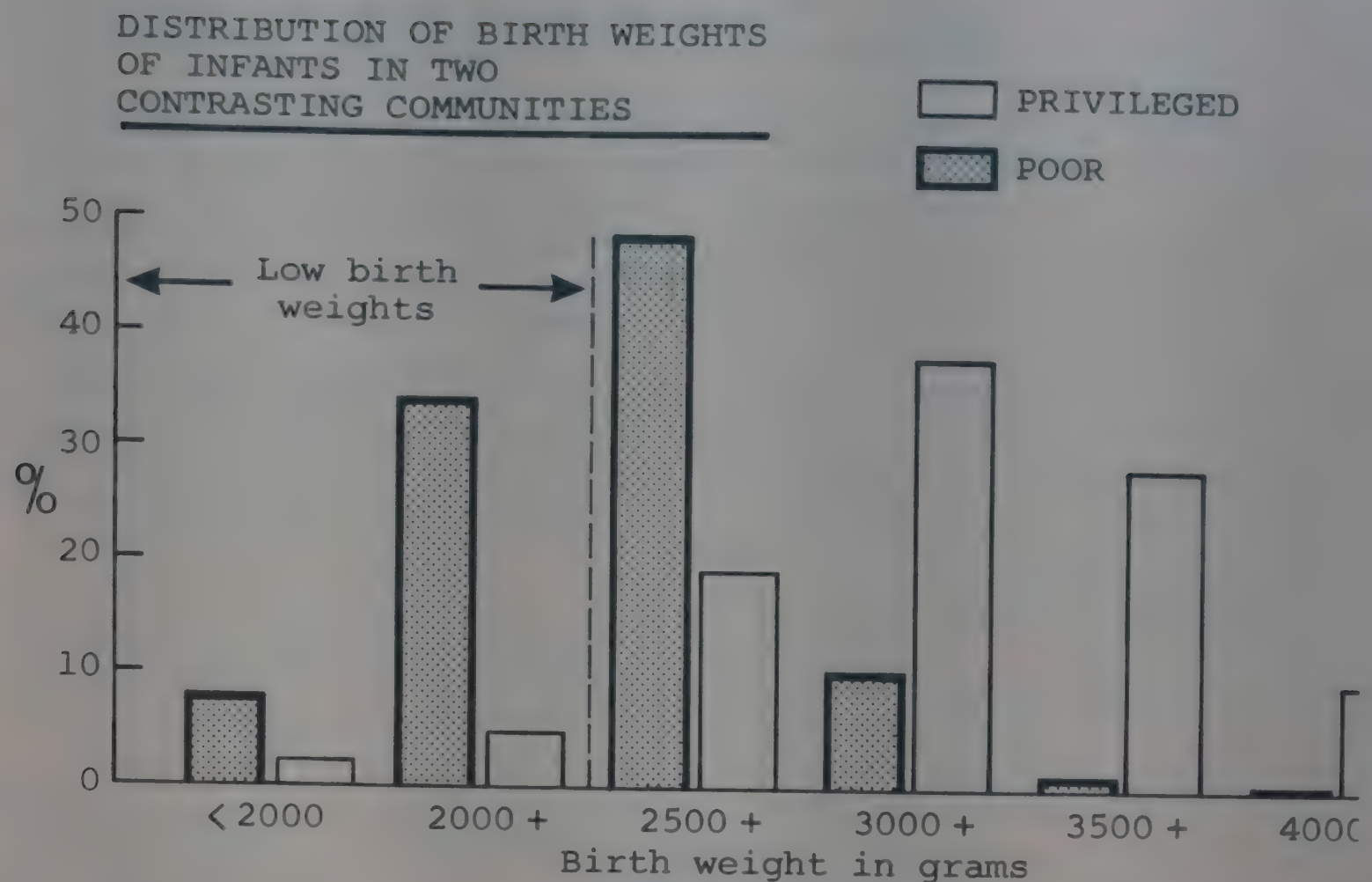
* Solon, F.S. (no date) Barangay health aids manual.
Chapter 4: Diagnosing the community. The steps to community diagnosis are situational analysis, problem identification, constraint analysis, plan formulation; implementation and evaluation. This is a step-by-step investigation and action. The objectives of community diagnosis are listed: the collection of population data (total, pre-school); to the collection of mortality data (total, infant); and obtaining information about transport, school/education, occupation/income, water supply and sanitation (toilets).

A checklist of "what to do" in every aspect of community diagnosis is provided. Example:

1. Total population of children (0-6 years).
Purpose: to identify priority group services.
Source: unit record.
What to do: (1) instruct unit leaders to submit the list of total numbers of 0-6 in a visit to the zone leader or directly to the Barangay Health Aid.
2. House: Type: number of rooms, description (nipa, cogon, wood...), things found around the house (garden, livestock).

This book is a good introduction to the subject.

Sterky, G. and Mellander, L. (1978) Birth weight distribution and indicator of social development. SAREC Report No. R2.



(SAREC report No.R:2,1978)

Fig. 10.1: Source TCHU: This picture may be reproduced.

TALC (no date) Plastic overlay sheets for the growth chart. Weights for age are recorded either from cards held at the home (one home in ten) or by weighing all the children under five who slept there the night before. The weights for age are recorded on a "master" card and when all the data is collected, the plastic transparent overlay (showing average weights for age) indicates the proportion of children who are not growing as well as they should.

* Uganda, Ministry of Health, Health Education Division (no date) Planning visual aids and simple methods of communication. Asks: Why a survey? and how it should be run. This is a somewhat abbreviated account of sophisticated sampling but a useful summary of one of the ways information can be collected.

UNESCO (1981) Children of disadvantaged families; contemporary studies in Western Europe: the relevance to developing countries by M. Manciaux (International Children's Centre, Paris). Unesco Division for the Study of Development Report ChR 18. 17pp.

UNESCO (1981) Some observations of family style and unequal opportunities for the development of children in the Gulf States by I.M. Kazem and L. Melikian, University of Qatar. Unesco Division for the Study of Development Report ChR 20. 22pp.

UNESCO (1976) The use of socioeconomic indicators in development planning.

UNESCO (1981) Women and development: indicators of their changing role. Unesco Socioeconomic Studies No.3.

* Werner, D. (1977) Where there is no doctor.

Pp. W26, W27: Using pictures to get people talking about the local community. Sample questions may include: (1) who are the people in the picture and how do they live?; (2) what was this land like before the people came?; (3) in what ways have they changed their surroundings?; (4) how do these changes affect their health and well-being?; (5) what other changes could these people make?; (6) how did they learn to farm? who taught them?; (7) if a doctor or a lawyer moved onto this land with no more money or tools than these people, could he farm as well? why or why not?; (8) in what ways are these people like ourselves?

What questions can you ask to get people thinking about the different things that lead to the condition of the child in the following picture?



Try to think of questions that lead to others and get people asking for themselves. How many of the causes underlying death from diarrhea (see p. w7) will your people think of when they discuss a picture like this?

Fig. 10.2.

"You can think of many other drawings and questions to start discussions that can help people look more clearly at problems, their causes, and possible solutions."

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Chapter 25, p.27: Taking a survey to find out about the nutrition

needs in the community.

"Some food and nutrition problems tend to go unnoticed, even by those who live in the village or neighbourhood where they exist. A good way to find out about these problems is to take a simple nutrition survey. As we discussed in Chapter 6, surveys of people often reduce their sense of dignity and control over their lives. However, surveys by the people in a community at times can help increase their understanding and control of the factors affecting their health.

The health worker can serve as the survey coordinator or facilitator (someone who makes it easier).

A simple community survey to check for nutritional problems can perform at least 4 functions.

1. It can help people determine how many persons in their area are poorly nourished. If more than 1 out of every 7 children (15%) is underweight or too thin, then the community probably has a serious food problem.
2. It can help show which children and which families have the greatest need and deserve special care and concern.
3. The health worker can use the survey to help interest, inform, and involve various groups in the community - mothers, fathers, schoolchildren, and community leaders.
4. The survey can provide a basis for comparison at a later date. People will be able to see if the action they have taken to improve nutrition in their village has been successful.

Different groups from the community can be involved in different aspects of a survey. For example:

School children might check to see whether their younger sisters and brothers are well nourished or too thin.

Midwives could help in reviewing the nutrition of pregnant women. Mothers could find out how many babies are breastfed or bottle fed and how this affects the babies' health.

Fathers might do a study on how the drinking habits of men affect the nutrition of different families.



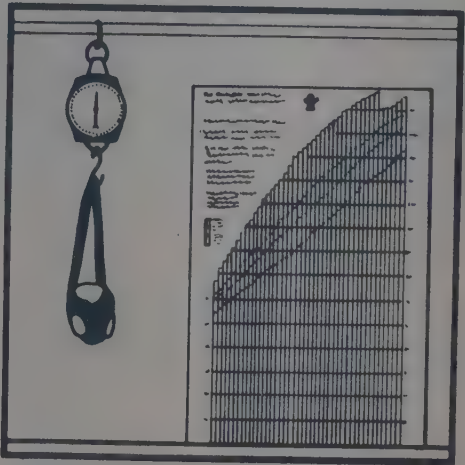
Fig. 10.3.

By helping to conduct their own survey, the villagers become more aware of the problems and the need for action to combat them. "However, if surveys are to be conducted by untrained people, they should be simple, quick and interesting. On the following pages we explore a variety of survey methods"

2. Weight-for-height: THE THINNESS CHART

For survey purposes, comparing a child's height to her weight is perhaps the most accurate way to check whether she is too thin. But until recently, this required complicated charts and was not practical.

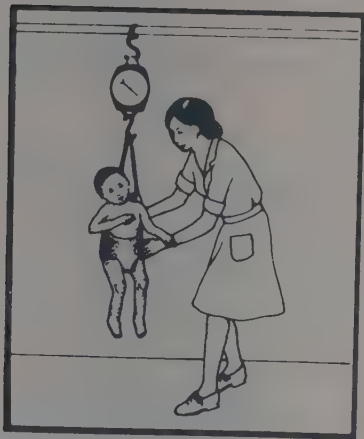
Fortunately, a new Thinness Chart has been developed. It is colorful, simple to use, and easy to understand. This is the way it is used:



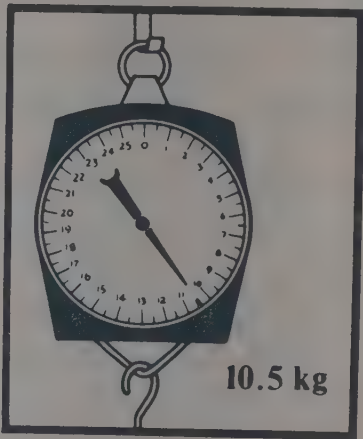
Hang the chart on a wall near the scales.

Be sure the bottom edge of it touches the ground.

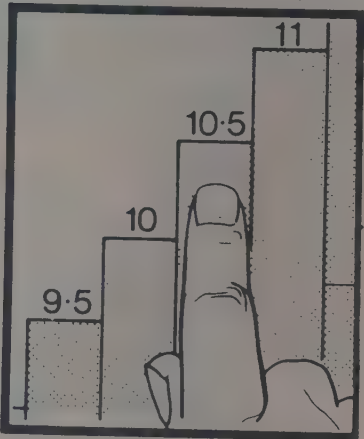
1. Weigh the child.



2. Note the weight.



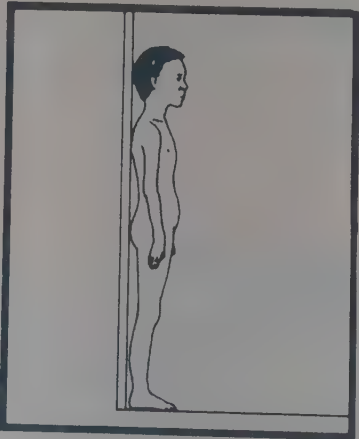
3. Find the weight on the chart with your finger.



4. Have the mother help the child to stand directly under your finger.



5. Check to see that the child's shoulders and feet are against the chart.



6. Make sure that the child's feet are against her weight as shown at the bottom of the chart.

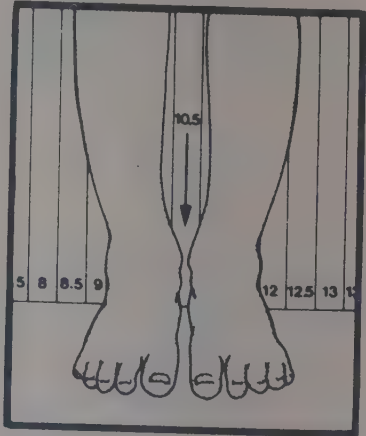
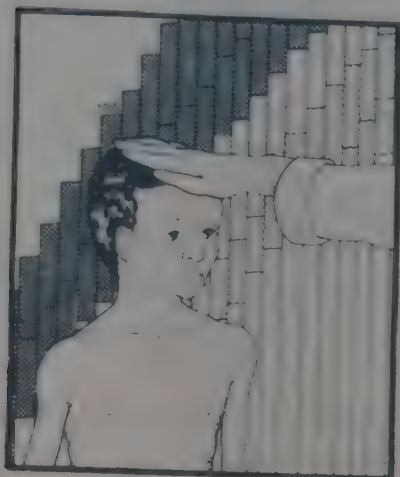
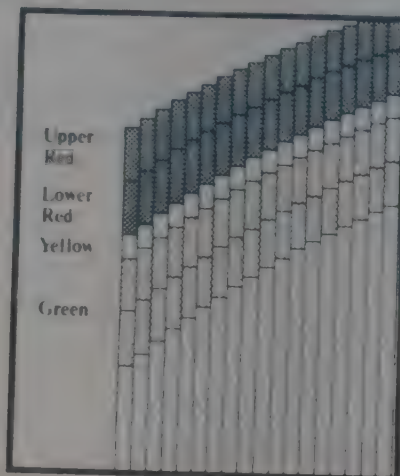


Fig. 10.4: Weight for height thinness chart. Chapter 25. P.10.

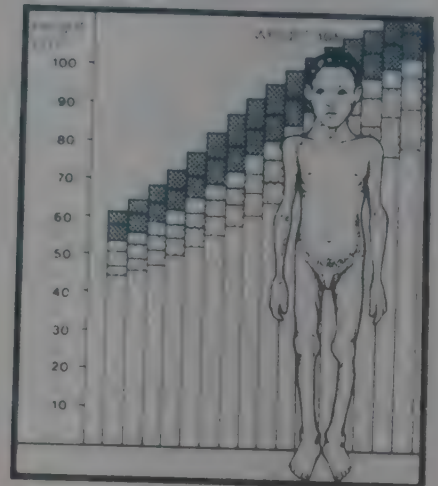
7. Now put your hand flat on the child's head. Which color does your finger touch?



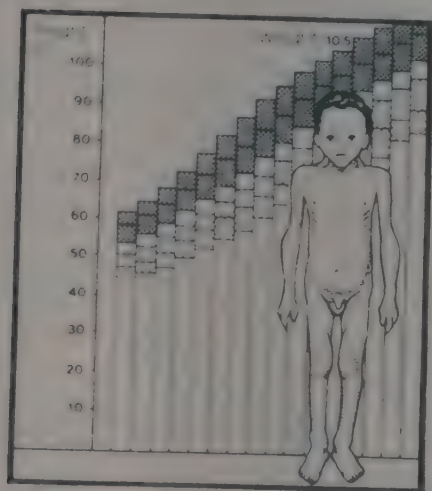
8. Is the child in the upper red, lower red, yellow, or green?



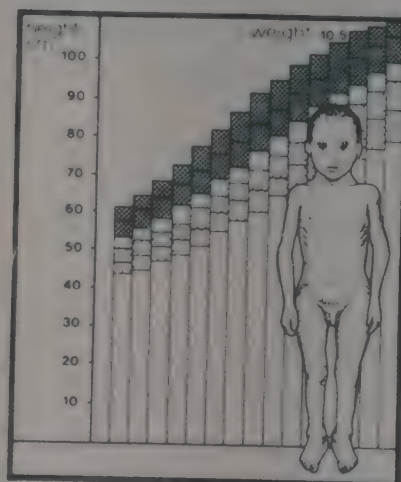
9. If the child is in the **upper red**, he is dangerously thin and needs **more food urgently**.



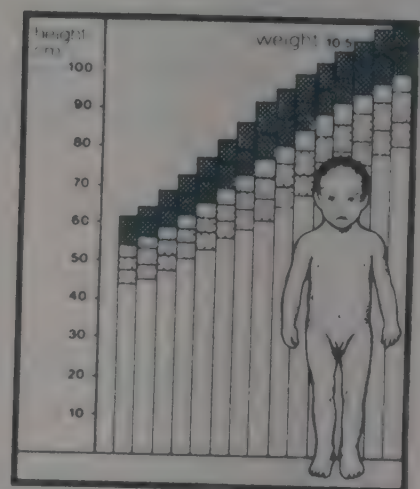
10. If the child is in the **lower red**, he is very thin and needs **more food at once**.



11. If the child is in the **yellow**, he is thin and **may need more food**. Check him regularly.

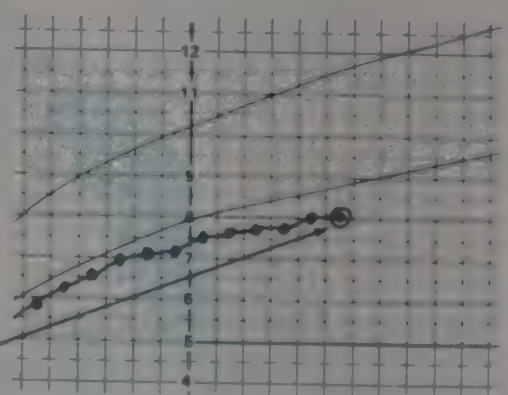


12. If the child is in the **green**, he is well nourished. **Three cheers!**



(Notice that the younger, smaller, well-nourished child on the right weighs as much as the older, very thin child on the left.)

The Thinness Chart is especially useful when children are measured only once—as in a survey. But it can also be used together with the Road to Health chart. It lets you know whether a child who measures below the Road to Health is too thin, or is simply smaller than average. If a child is too thin according to the Thinness Chart, this can be noted on the Road to Health chart. Simply put a **RED CIRCLE** around the dot on the chart, like this:



PRECAUTION: At first the Thinness Chart may confuse persons who have used the Road to Health chart. This is because on the Road to Health chart, the thin child appears **below** the level of the well-fed child. But on the Thinness Chart, the thin child appears **higher** on the chart than a well-fed child of the same weight. This difference needs to be carefully explained.

Fig. 10.4. cont.

Chapter 25, p.23:
 "Making survey and discussion questions specific not general.
 The need is to be very specific when asking people questions. Do
 not ask big, general questions that may be difficult to answer.
Ask people questions about themselves"

LESS APPROPRIATE QUESTIONS	MORE APPROPRIATE QUESTIONS
Do the people in your village raise small animals?	How many chickens does your family have this year? How many goats? How many rabbits?
What foods are usually given to little children?	What foods do you give your child? What did your child eat today?
At what age do children stop getting their mother's milk?	At what age did your child stop getting your milk? (If the mother doesn't know, ask more questions: Did the child have teeth then? Could the child walk?)
What does your family usually eat?	What did you eat since this hour yesterday? What did your husband eat? What did your little children eat? What did your older children eat?

Table 10.1.

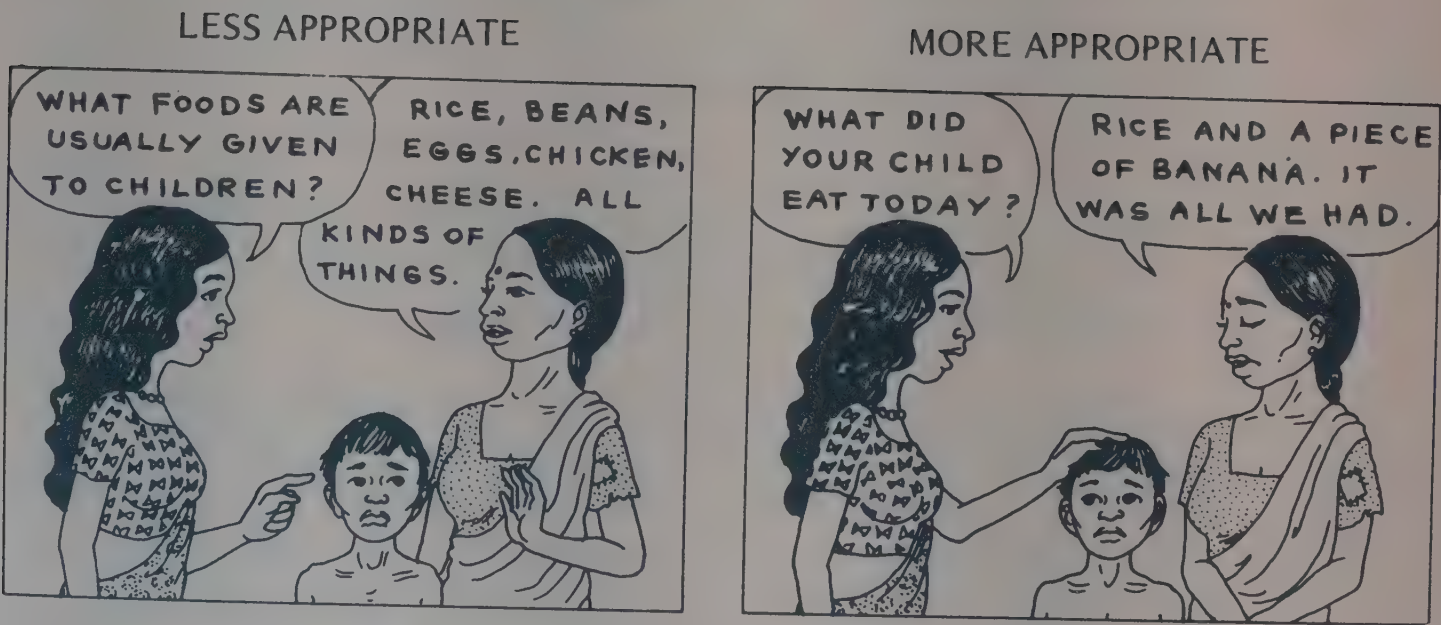


Fig. 10.5: Making questions specific helps people give answers that are closer to their day-to-day reality.

Chapter 26, pp.3,4: Teaching diagnosis of the chain of causes of death.
"The story of Luis
 Consider Luis, a 7 year old boy who dies of tetanus. Luis lived

with his family in the small village of Platanar, 11 km. by dirt road from the town of San Ignacio. In San Ignacio there is a health centre staffed by a doctor and several nurses. The health centre conducts a vaccination programme and has a Jeep. But the vaccination programme only occasionally reaches nearby villages. One year the health team began to vaccinate in Platanur, but after giving the first vaccination of the series, they never returned. Perhaps they grew discouraged because many parents and children refused to cooperate. Also, the road to Platanar is very dusty and hot.

When the staff of the health centre failed to return to Platanar, a midwife from the villages went to San Ignacio and offered to take the vaccine to the village and complete the vaccination series. She explained that they knew how to inject. But the doctor said no. He said that unless the vaccines were given by persons with formal training, it would be putting the children's lives in danger.

Three years later, the boy Luis took a bucket of food scraps to the pen where his family kept a mother pig and her piglets. On the way, he stepped on a long thorn with his bare foot. Normally Luis wore sandals, but his sandals had broken 3 days before and were too worn out to repair. Luis's father was a sharecropper who had to pay half his maize harvest as rent for the land he farmed. He was too poor to buy new sandals for his son. So Luis went barefoot. The boy pulled the thorn from his foot and limped back to the house.



Fig. 10.6.

Nine days later, the muscles in Luis's leg grew stiff and he had trouble opening his mouth. The following day, he began to have spasms in which all the muscles in his body suddenly tightened and his back and neck bent backwards.

The village midwife at first called his illness congestion and recommended an herbal tea. But when the spasms got worse, she suggested that Luis's parents take him to the health centre in San Ignacio.

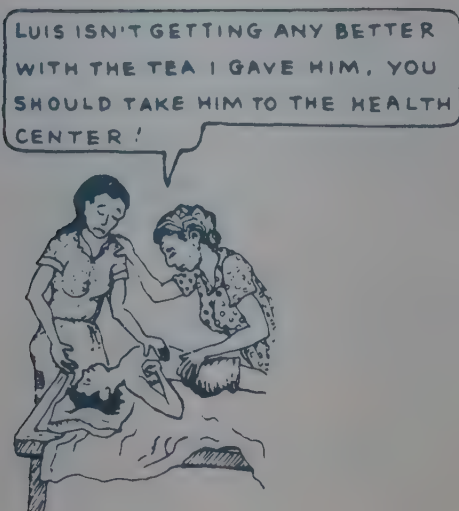


Fig. 10.7.

The family paid one of the big landholders in Plantanar to drive to San Ignacio in his truck. They had managed to borrow 500 pesos, but the landholder charged them 300 for the trip. This was much higher than the usual price.

In San Ignacio, the family waited for 2 hours in the waiting room of the health centre. When it was finally their turn to see the doctor, he at once diagnosed the illness was tetanus. He explained that Luis was in grave danger and needed injections of tetanus antitoxin. He said these were very expensive and, in any case, he did not have them. They would need to take Luis to the city of Mazatlan, 100km. away.

The parents despaired. They had barely enough money left to pay the bus fare to Mazatlan. If their son died, how would they get his body back to the family graveyard in Platanar?

So they thanked the doctor, paid his modest fee, and took the afternoon bus back to Platanar. Two days later, after great suffering, Luis died.

The chain of causes

To help the group get a better idea of the chain or network of causes leading to illness and death, an actual chain can be formed. Each time another cause is mentioned, a new link is added to the chain.

Draw the chain on a blackboard or a large sheet of paper. Or cut out cardboard links, and drawings of Luis and a grave. These can be hung on a wall or fixed for use on a flannel-board.

The chain of causes leading to Luis's death from tetanus might begin something like this.

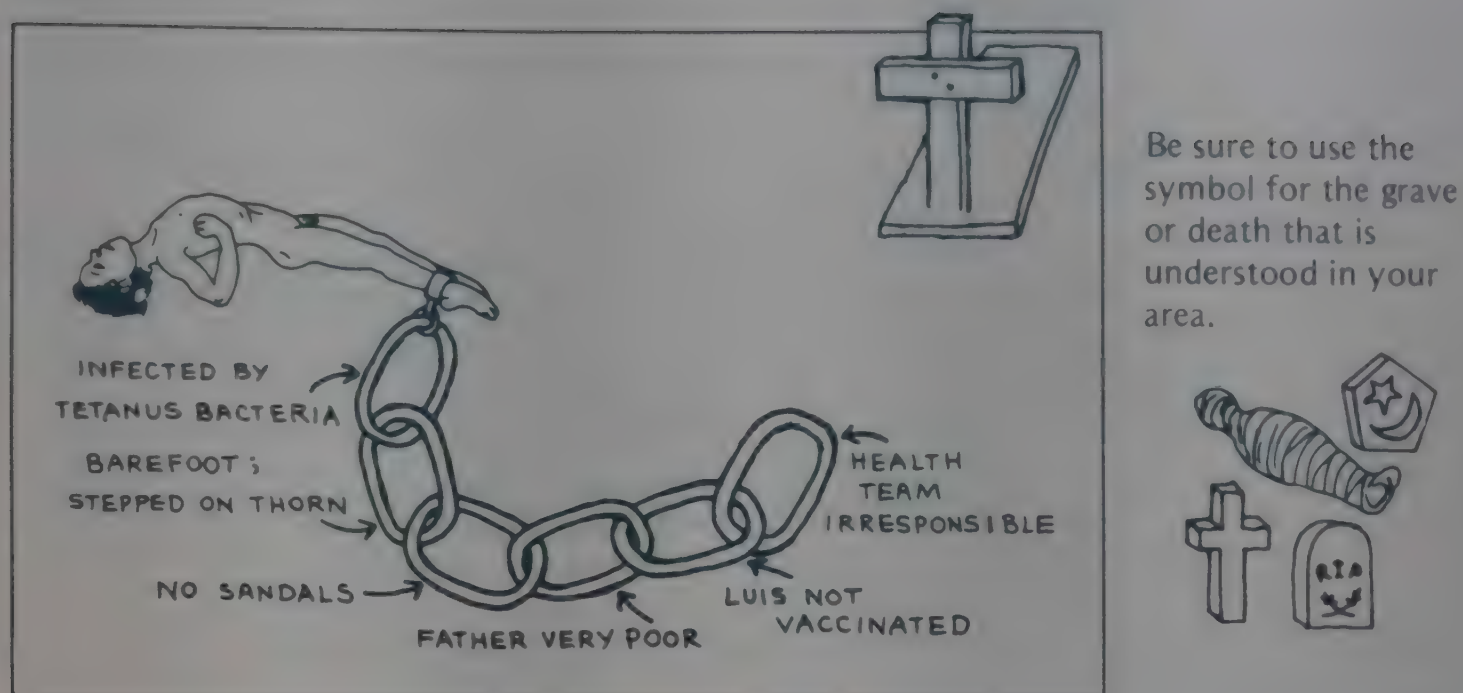


Fig. 10.8.

You can use 5 different colours of links to represent the 5 kinds of causes. Students can help make cardboard or flannel links themselves.

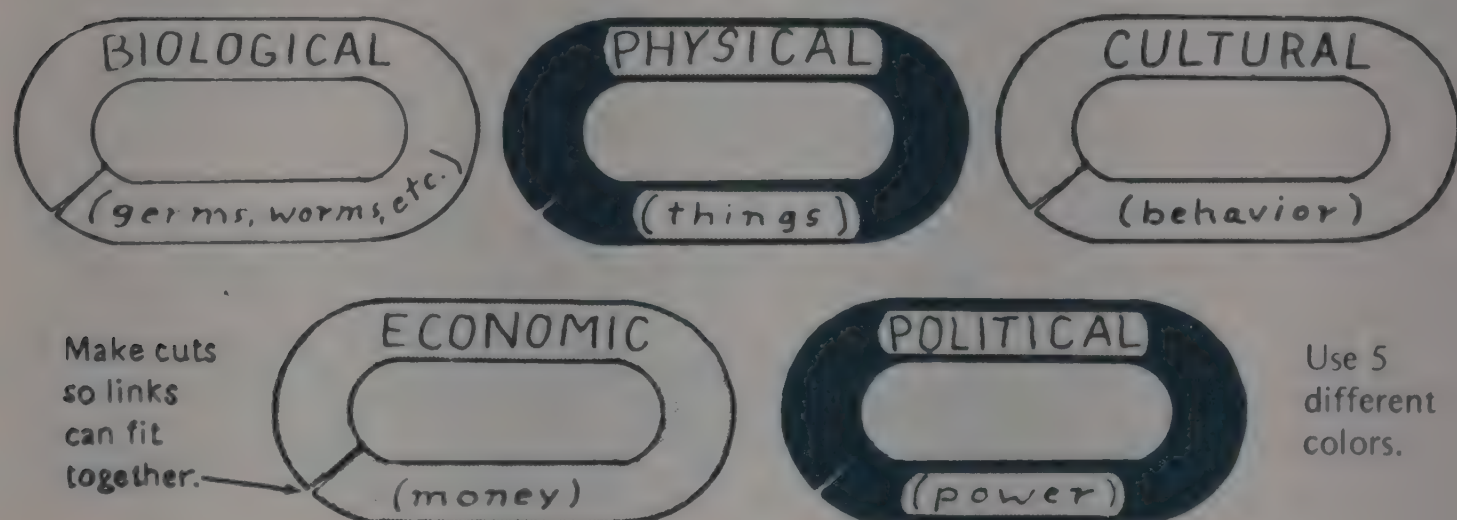


Fig. 10.9.

The group can form the 'chain of causes' as they play the game 'But why?' or as a review afterwards. Give each student a few links. Then, each time a new cause is mentioned, everyone considers whether it is biological, physical, cultural, economic, or political. Whoever has the right link for a particular cause, comes forward and adds the link to the chain ..."

		Yes	No
"B-8	Do insects, animals, or diseases attack the plants in the field?		
B-9	Do the plants lack water (rain, irrigation)? ...		
B-10	Do the families lack good places to store food?		
B-11	Could the families raise small animals for food?		
B-12	Do serious diseases attack the animals?		
B-13	Could the families gather more wild foods, or could they hunt or fish?		
B-14	Do the families sell their food instead of feeding it to the children?		
C.	BUYING FOOD		
C-1	Do the families buy some of their food? -If YES, go to C-2 If NO, go to D-1		
C-2	Do shops and markets often lack important foods?		
C-3	Do the families lack the money to buy the foods for sale?		
C-4	Does food cost too much because transporters and shopkeepers raise the prices?		
C-5	Do the workers lack regular jobs?		
C-6	Do men working far away fail to send money to their families?		
C-7	Do the families have trouble selling their handicrafts or their animals and crops?		
C-8	Do the families buy the wrong foods (such as soft drinks, alcohol, powdered baby formulas, and expensive meats)?		
D.	FEEDING THE CHILDREN		
D-1	Do the mothers choose not to breastfeed their babies, or do they stop breastfeeding too soon?		
D-2	Are the mothers malnourished so they do not have enough breastmilk for their babies?		
D-3	Do the mothers stop breastfeeding their children suddenly or too harshly?		
D-4	Do the mothers get pregnant again soon?		
D-5	Do the families feed babies tinned milk or instant formulas?		
D-6	Do the babies start getting solid foods at the wrong age?		
D-7	Do the mothers leave their babies with people who do not feed them well?		
D-8	Are the children poorly fed because their families are separated (by jobs, illness, divorce, death)?		
D-9	Do the little children eat only 1 or 2 times a day?		
D-10	Do the families fill the children's stomachs with bulky foods (like cassava) that have few proteins or calories?		
D-11	Are the adult foods hard for little children to eat and digest?		
D-12	Do the adults and older children eat most of the food before the little children get any?		
D-13	Do traditions keep mothers and young children from eating important foods?"		

Chapter 3, p.16:

Making a chart of common diseases in the area.

"The flannel-board could look something like this:"

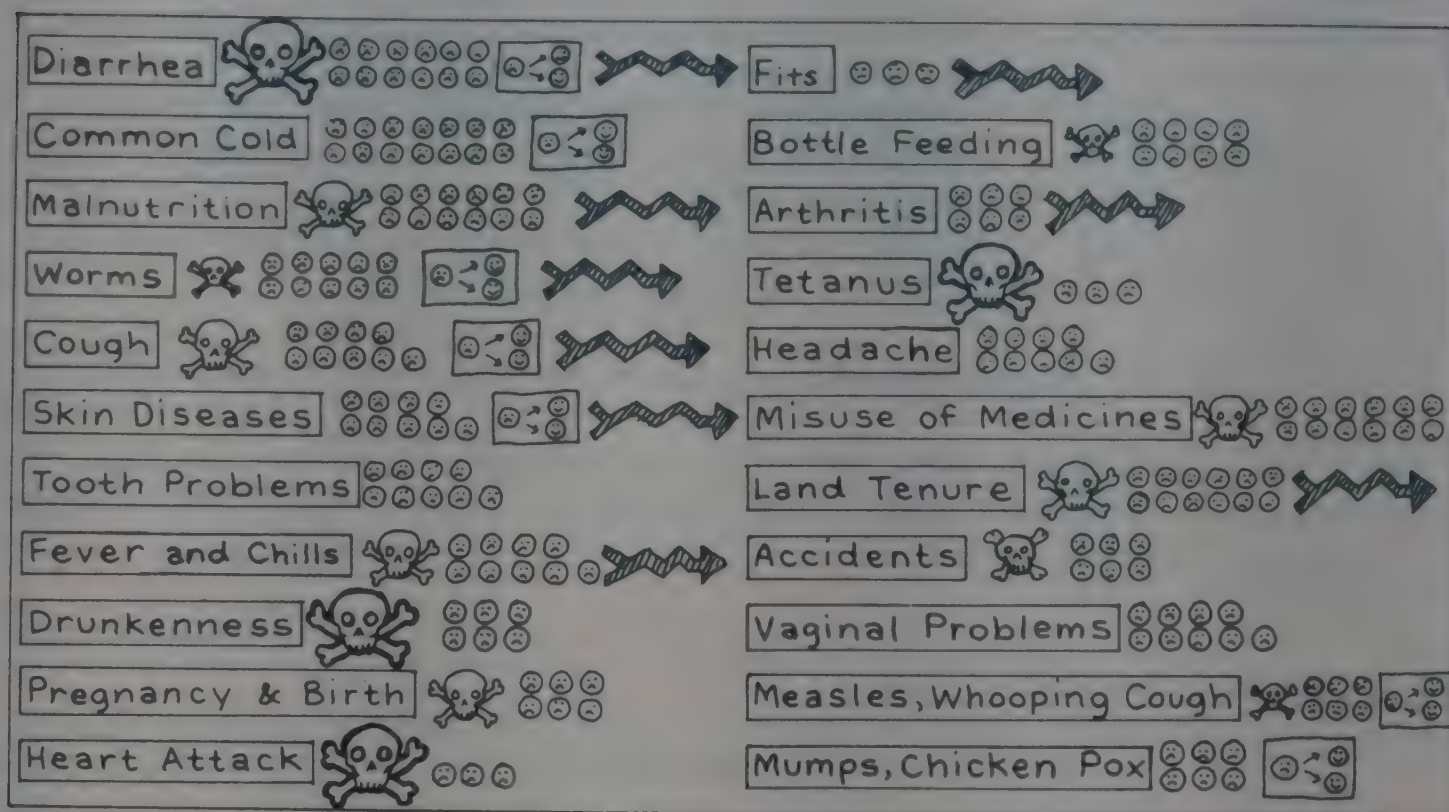


Fig. 10.10

* Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981)
Community health.

Many relevant sections including:

P.14: Who are the high risk groups;

P.21ff: The community diagnosis;

P.33: Behaviour, environment and health;

Chapter 4: The pattern of health and disease;

Pp.157-160: How well are the health services working?;

Pp.170-172: Organising a survey.

* World Bank (1979) Health sector policy paper.
Contains many national statistics.

* World Bank (1975) Integrating women in development; Why?
When? How?

There is a useful checklist in the appendix to help planners to find out how women's lives may be affected by new developments and how women may need to be included in local participation efforts, project goals, evaluation reports and project planning, and implementation teams.

World Bank (1979) Recognising the "invisible" woman in development: the World Bank's experience. 33pp.

* World Bank (1980) Women in development. Pamphlet.
Case studies to bring into focus the important role of women in development.

* World Bank (annual) World development indicators.
National data.

World Bank Reprint Series

- (1) Basic needs, some issues by Paul Streeten, Shahid Javed Burki (1978). Reprint Series No.53.
- (2) Social accounting matrices for development planning by G. Pyatt and J.I. Round. Reprint Series No.74.
- (3) Indicators of development: the search for a basic needs yardstick by N. Hicks and P. Streeten (1979) Reprint Series No.104.
- (4) Poverty: some measurement problems by T.N. Srinivasan. (1977) Reprint Series No.77.

* World Council of Churches (1971) Community health and the church.

A small booklet which raises questions including "What are the health needs?" and "How much information gathering is needed?" etc.

* WHO (1977) Out of the ivory tower. 16mm. film. 10 mins. colour. Eng.

Medical schools have lived too long in splendid isolation, isolated from the reality of the everyday health problems of the communities around them. This is particularly serious in developing countries where so many are urgently in need of care. The film shows how a medical school in Rajasthan, India, has tackled the problem by making a service to the community a regular part of the curriculum. Rajasthan is a desert area and, in the film, medical students and nurses are shown giving care in a rural health centre. The traditional methods of the teaching hospital with its courses, lectures and exams are contrasted with dynamic attempts to bring the students to the people through house-to-house visits in the poorer urban and remote rural areas.

WHO (1981) Potential learning resources in a village.
Appropriate Technology for Health Newsletter. No.10: p.10.

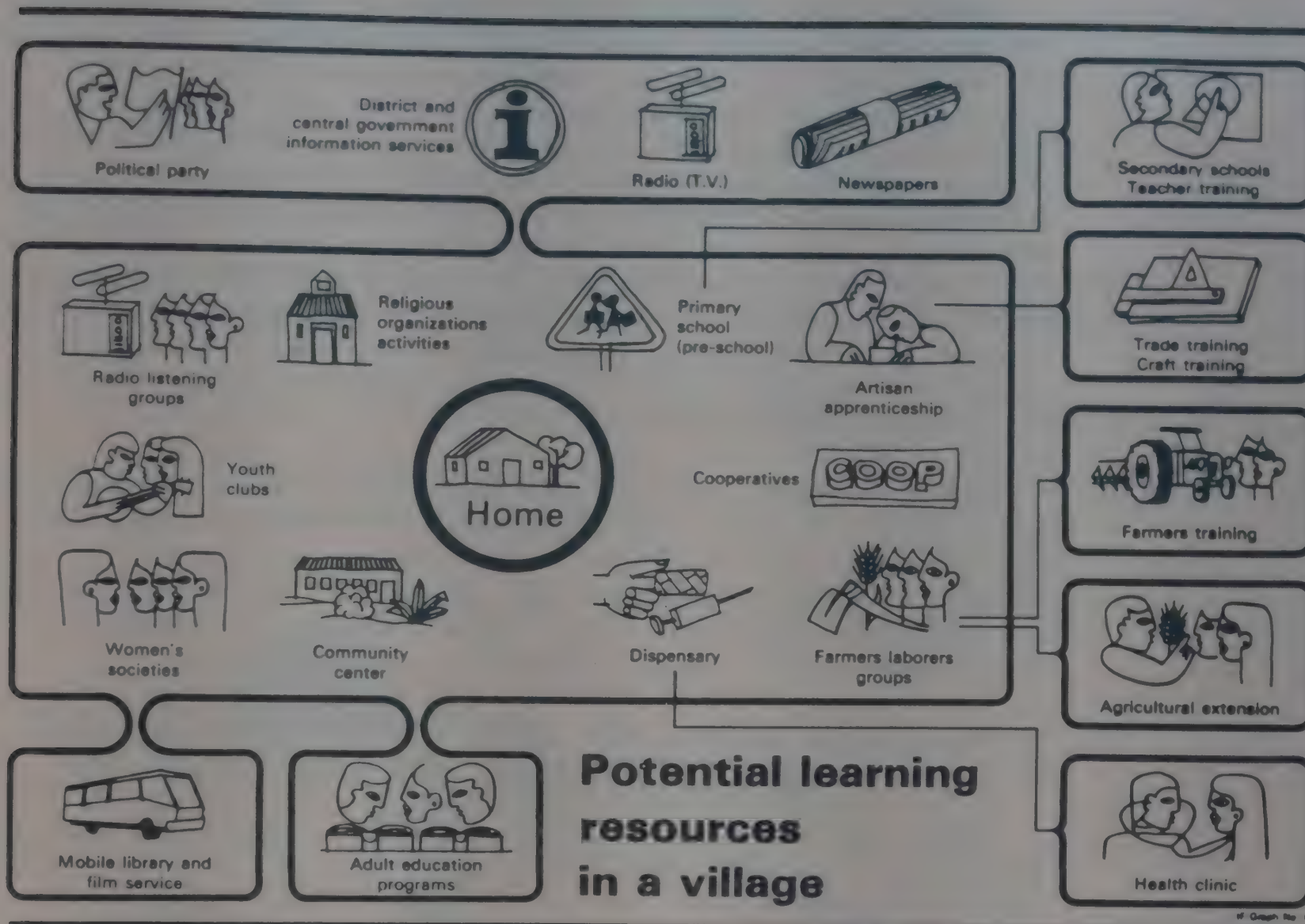


Fig. 10.11.

WHO (1981) Risk approach for maternal and child health. A selected annotated bibliography. MCH/RA/81.1.

WHO, Eastern Mediterranean Regional Office (1981) Traditional practices affecting the health of women and children, report of a seminar held in Khartoum, 1979. WHO/EMRO Tech. Pub. No.2.

WHO/International Epidemiological Association (no date) Planning and organising a health survey, a guide for health workers. 112pp.

A very useful first book in a series to be available from the Development of Health Statistics unit in Geneva. Other booklets will include sampling, using information, designing questionnaires, interviewing and recording, abstracting, processing and presenting survey information.

10.2. Making a plan for provision of better mother and child health care

See also bibliography Sections as follows:

- 1.1.5.1. Planning antenatal care;
- 1.2.6. Planning delivery care;
- 1.3.3. Planning organisation and evaluation of postnatal services;
- 2.2. How can child nutrition problems be tackled?;
- 4.3.1. Finding out the need for birth spacing services.

- * Abbatt, F.R., Jonsson, R.J. and Martin, J.D. (1982) Manual for training district level staff in the planning and management of health care in Zambia. Trainer's manual.
A manual in four sections (white, yellow, blue and pink): i.e. Introduction, Exercises and case studies of management at district level, Teaching methods, and Technical handouts. The terms used, such as planning, organising, co-ordinating, supervising and evaluating, are elaborated in the case studies; e.g. planning also means obtaining information; analysing this information; using the information; decision making; monitoring and evaluating; communicating and working in teams; training and developing personnel and organising training programmes; financial management; budgeting, etc.

- * Amonoo-Lartson, R., Ebrahim, G.J., Lovel, H.J., and Ranken, J.P. (1984) District health care. Challenges for planning, organisation and evaluation in developing countries.
Chapter 2: Making a plan for the district. Having identified problems and resources, this chapter covers task-setting procedures, useful ideas relevant to many countries.

- Backett, E.M., Davies, A.M. and Petros-Barvazian, A. (1983)
The risk approach in health care. WHO Public Health Paper No.76.

- * Green, A.C. and Gentile, P.H. (1974) Planning in district management. Use of a teaching game.
Lancet 2: pp.337-340.

- Djukanovic, V. and Mach, E.P. (eds.) (1975) Alternative approaches to meeting basic health needs in developing countries; a joint UNICEF/WHO study.
Useful but expensive for local purchase.

- * Ebrahim, G.J. (1976) A model of integrated community health care; Simavi essay. Trop. Geog. Med. 28: pp.550-552.
Includes a jigsaw puzzle of the different activities that need to fit together to help rural development and thus child health: employment, education, access to markets, system of land tenure, agriculture, community development, and health care.

- * Elliott, K. (1975) The training of auxiliaries in health care; an annotated bibliography.
A short annotated bibliography divided into sections: material for auxiliaries; material for teaching courses for auxiliaries; background material for planners of auxiliaries; background material for planners of auxiliary work.

- * Indonesia, Directorate General of Community Health (1976)
Health centre reference manual. Vol. I. Section on programme planning.
A detailed and clear description of programme planning. P.1/V/4 contains a very useful table on which staff members and project heads can fill in their plans.

- * Jelliffe, D.B. (1974) Child health in the tropics; a practical handbook for medical and paramedical personnel. 4th edition. 170pp. Eng. Sp.

Includes the organisation of school health services; feeding school children; physical activities; health education; immunisation.

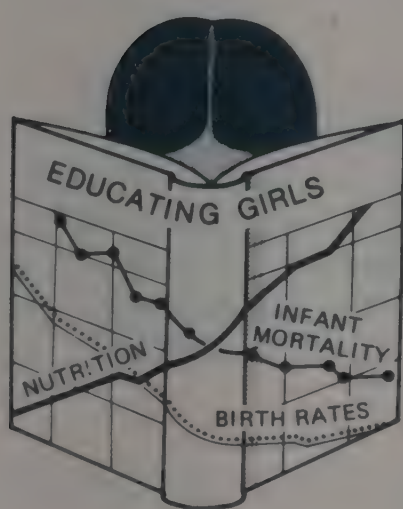
* **Mabry, E.G.** (no date) Planning a community health programme. 56pp.

P.8: Includes guidelines for determining priorities.

* **Morley, D.C. et al.** (1984) The child's name is today. A collection of pictures raising issues to be covered in planning for better mother and child health care.

* **Morley, D.C.** (1973) Paediatric priorities in the developing world.

Lists the main subjects that need to be covered in a child care training programme.



THE EDUCATION OF GIRLS
IS CLOSELY ASSOCIATED
WITH A FALLING INFANT
MORTALITY AND BIRTH RATE
AND IMPROVED NUTRITION

Fig. 10.12: The impact of educating girls on infant mortality and birth rates.

Source TCHU. This picture may be reproduced.

PAHO/WHO (1982) Preparation of health services personnel in primary health care, with emphasis on maternal and child health. Working guide, guidelines for adaptation, guidelines for community based training. Experimental edition.

Emphasises continuing education, team work and the application of the risk approach. Detailed educational objectives are included.

* **Philippines, Rural Missionaries** (1978) Community based approach to health; selected readings. Many are reproduced in a special issue of Contact.

A very useful summary booklet. Includes a study of the roots of the health problem.

* **Philippines Rural Missionaries** (1976) Go to the people, live with them, learn from them, love them, start with what they know, build on what they have. Diocesan community based health programmes, 1976 workshop recommendations.

* **Puffer, R.R. and Serrano, C.V.** (1973) Patterns of mortality in childhood. 38pp.

Excerpts of data from a ten-country study are succinctly

presented, describing childhood problems found the word over. Such data can help planners to estimate the need for child care services.

* **Solomon Islands** (no date) Programme planning for rural health clinics.

Excellent low cost pamphlet covering; the duties of health clinics; why there should be a plan; and the six stages of the planning process. It includes short straightforward questions for keeping track of work that has been done.

UNICEF (1981) Planning for children in national development (Sri Lanka); and Appropriate technology for primary child care. Both by D.P. Haxton.

* **UNICEF** (1982, reprinted 1983) The state of the world's children.

Contain very useful introductions to the insidious influence of under-nutrition.

* **UNICEF** (no date) UNICEF and the rights of the child.

Outlines with sensitive illustrations the needs of children for: a name; a nationality; adequate prenatal and postnatal care; adequate nutrition; adequate housing; adequate medical care; special care for the handicapped; parental affection; love and understanding; an education; a way of learning to be useful member of society; the proper development of abilities; and the enjoyment of play and recreation.

* **Vaughan, J.P. and Walt, G.** (no date) An introduction to primary health care in developing countries.

* **Werner, D.** (1977) The village health worker, lackey or liberator? 16pp.

There is a choice of approaches in health care: to take care of others or to help others to care for themselves. Two types of programmes can be recognised: community supportive, those which favourably influence the long range welfare of the community; and community oppressive programmes, those which, while giving lip-service to community input, are fundamentally authoritarian, paternalistic, encouraging dependency, servility and unquestioning acceptance of outside regulations and decisions, thereby crippling the community in the long run.

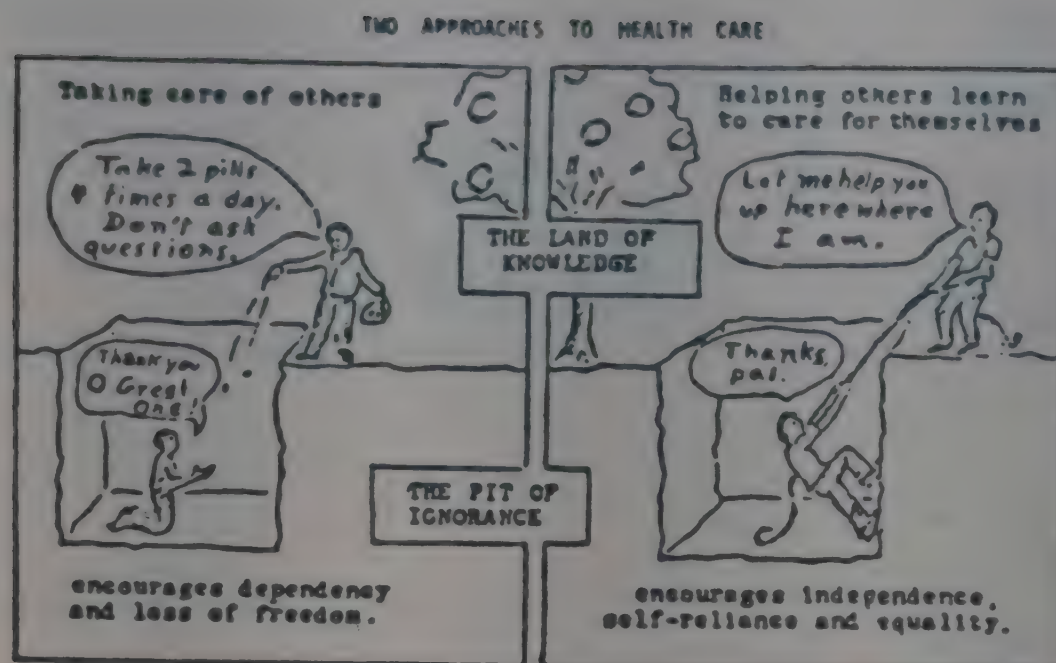


Fig. 10.13.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Contains many relevant sections.

For example, Chapter 25, p.31: areas that can be covered in a nutrition course based on short term and long term problem solving for emergencies: major problems, ongoing needs and underlying needs.

"Possible areas to cover in a nutrition course - based on short-term and long-term problem solving.

Emergency problems

Starving children.
Poorest families lack food.
Parents do not give sick children enough liquid or food (starving the sick).
Natural disasters.

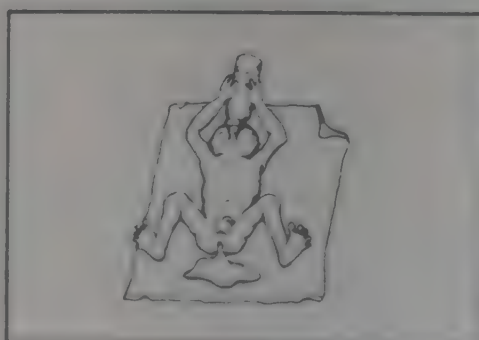


Emergency measures

Food supplements.
Centres for feeding malnourished children.
Oral rehydration.
Full, normal feeding for children with diarrhoea or other illness.

Major problems

Underweight children.
Loss of healthy customs (such as breastfeeding).
Certain unhealthy or mistaken customs (new and old).
Lack of knowledge about healthy foods.



Solutions to major problems

Under-fives clinics.
Baby weighing.
Nutrition classes for mothers.
CHILD-to-child activities.
Child spacing.
Better eating habits.
Looking for what is best in both old and new ways.

Ongoing needs

More and better foods.
Greater self-reliance.
Fairer distribution of land and resources.

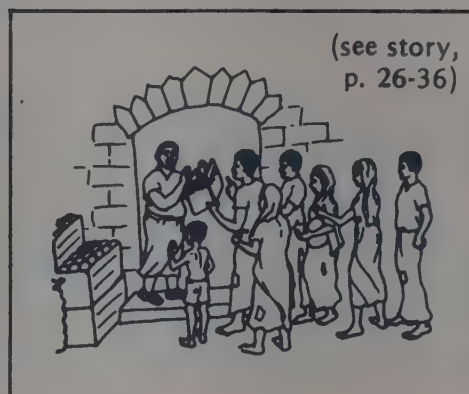


Partial solutions

Family gardens.
Improved farming methods.
Improved storage.
Food crops, not cash crops.
Mothers and children as nutrition workers.
More jobs (cottage industry etc.).
Rotating loan programme allowing poor families to buy their own land.

Underlying needs

Equal opportunity for everyone.
More control by people over their lives and their health.
Honest leaders.
Social justice.



Toward long-term solutions

Raising awareness.
Community organisation.
Change toward people-supportive government.
Redistribution of land.
Relevant education.
Fairer wages.
Restriction on advertising and profiteering by big business.
Fairer representation and bargaining power for the poor.

Fig. 10.14.

Wignaraja, M. (1978) Frameworks of development and implications for project design and evaluation. Paper presented at an OECD meeting on relevant development in basic needs perspective 8-11 May 1978.

Alternative approaches to designing a project are described:

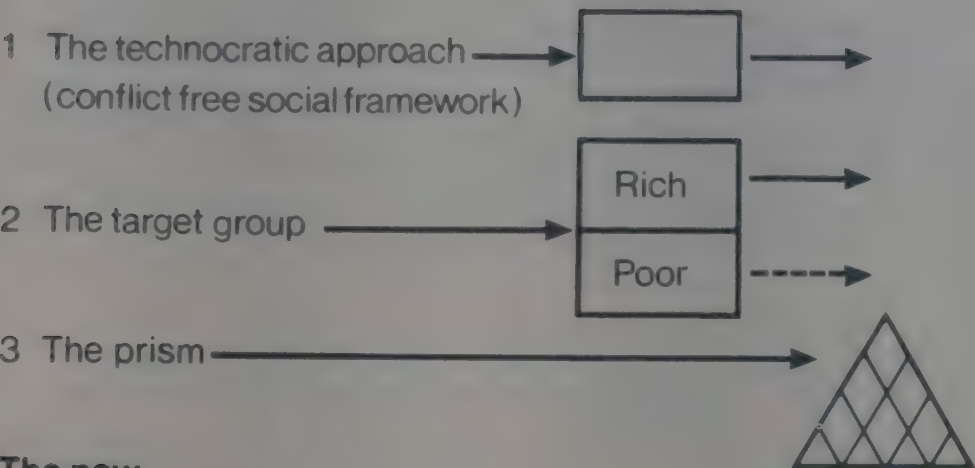
(a) The technocratic approach assuming a conflict-free social framework.

(b) The target group approach, focusing on e.g. the rich, or the poor.

(c) The prism approach, recognising the multiple approaches needed: (i) to see the contradiction tree of interests of different groups; e.g. the landless, the young, religious groups, different castes, women, (ii) to emphasise training for initiating and multiplying activities; (iii) to build organisations of and among the poor; and (iv) to strengthen critical institutions, village forum assemblies, village organisations, workers' groups, youth groups, landless labour etc; and the village fund.

Project designing

A The conventional approach



B The new

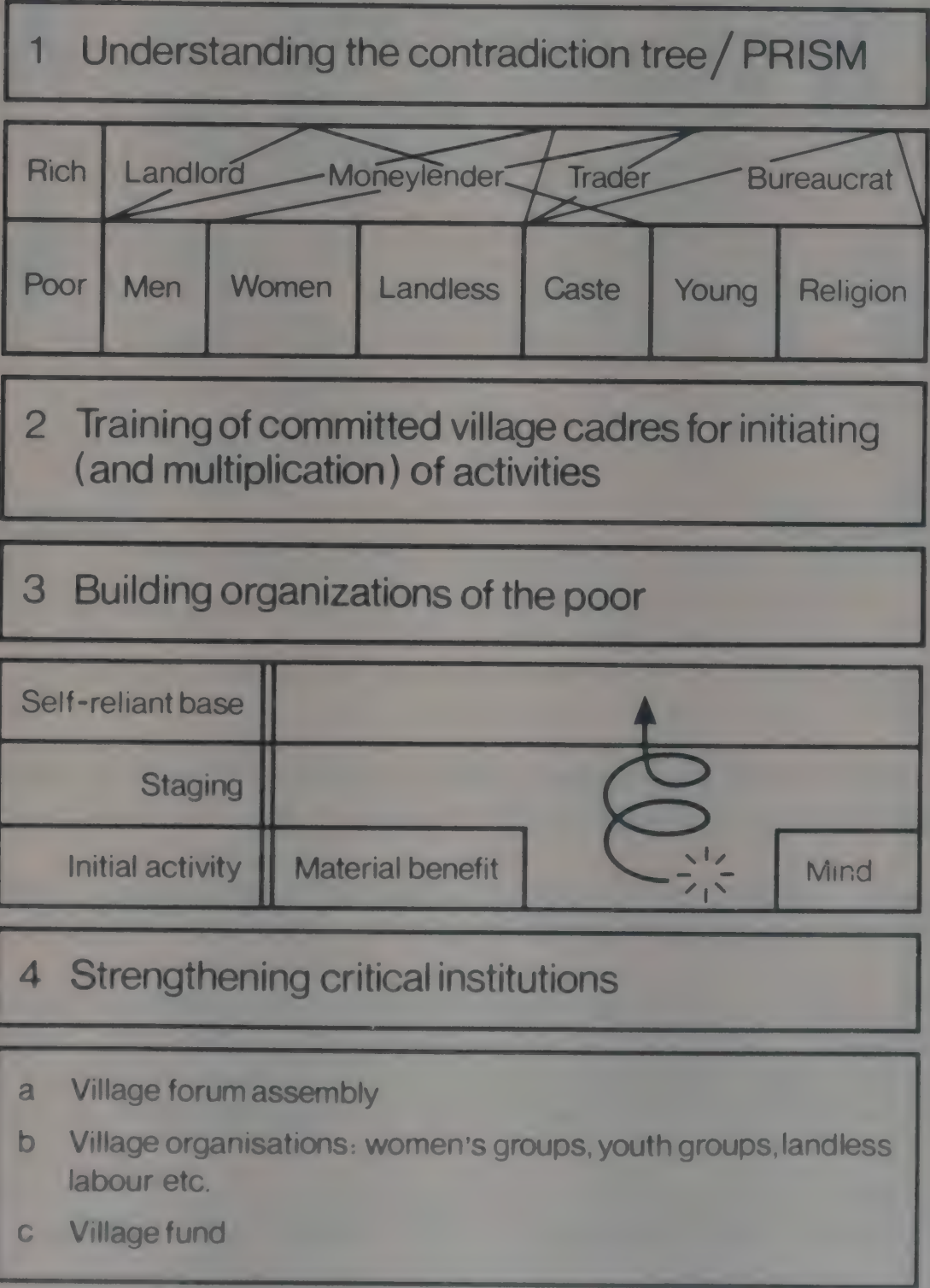


Fig. 10.15.

Williams, C.D. and Jelliffe, D.B. (1972) Mother and child health; delivering the services.
Includes section on the reasons for providing maternal and child health services; common health problems in children; organisation; personnel; and training.

* Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981) Community health.

P.4: Planning needs to be based on a clear understanding of where, in the pathway of disease, intervention is planned and where prevention is focused: primary, secondary or tertiary.

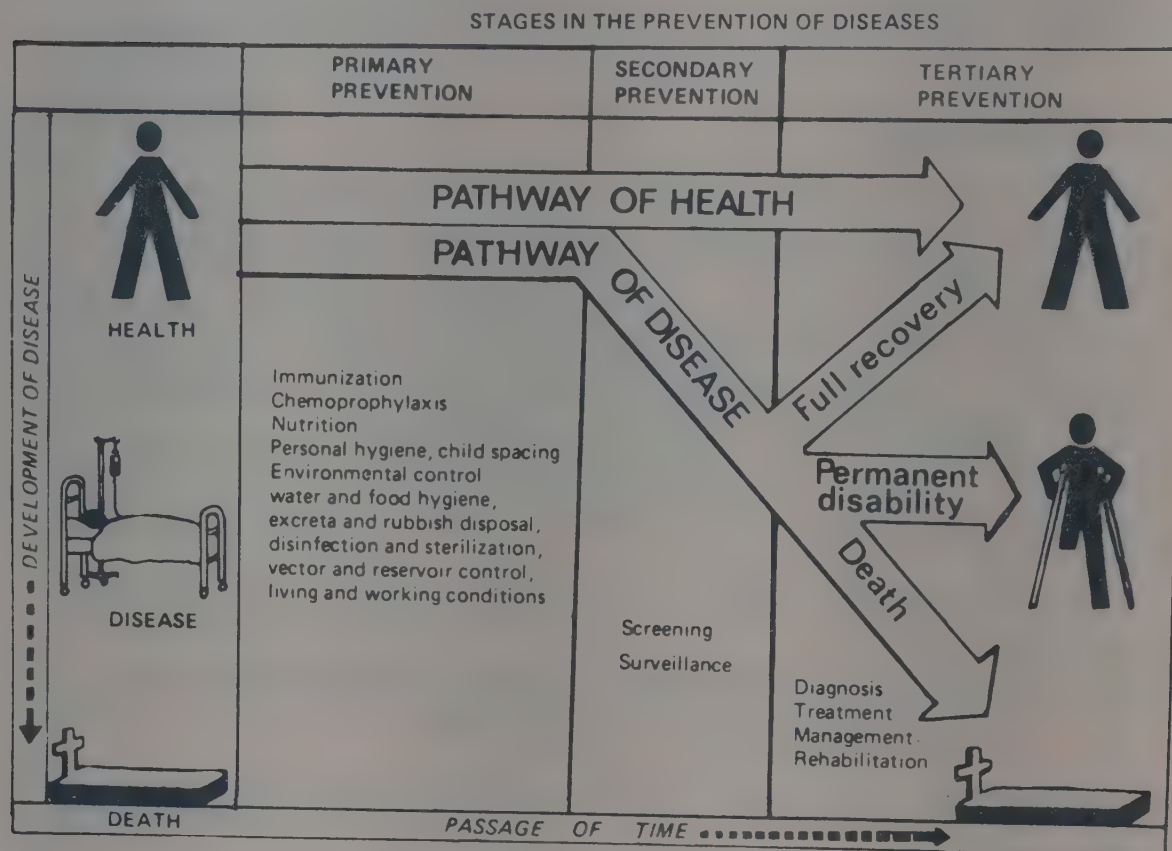


Fig. 10.16.

* World Food Programme (WFP) (1979) Women in food for work, the Bangladesh experience.

* WHO (1981) Analysis of the content of the eight essential elements of primary health care. HPC/PHC/REP/81.1.

WHO (1975) Annotated bibliography of teaching-learning materials for schools of nursing and midwifery. WHO Offset Pub. No.19. Eng. Fr. Sp.
An annotated bibliography for use by teachers and administrators.

* WHO (1981) Health for all by the year 2000. Special issue of World Health Magazine. February/March, 1981.

* WHO "Health for all" series Eng. Fr. Sp. Arabic. Chinese. Russian.

This series consists of selected important documents on the policies, strategies and processes for reaching WHO's main social goal: the attainment by all peoples of the world of a level of

health that will permit them to lead a socially and economically productive life:

- No.1. (1978) Alma-Ata 1978. Primary health care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978. Jointly sponsored by WHO and UNICEF. 79pp.
- No.2. (1979) Formulating strategies for Health for All by the Year 2000. Guiding principles and essential issues. 59pp.
- No.3. (1981) Global strategy for Health for All by the Year 200. 90pp.
- No.4. (1981) Development of indicators for monitoring progress towards Health for All by the Year 2000. 91pp.
- No.5. (1981) Managerial process for national health development. Guiding principles for use in support of strategies for Health for All by the Year 2000. 61pp.
- No.6. (1981) Health programme evaluation. Guiding principles for its application in the managerial process of national health development. 47pp.
- No.7. (1982) Plan of action for implementing the global strategy for Health for All by the Year 2000, and Index to the "Health for All" series, Nos. 1-7. 58pp.
- No.8. (1982) Seventh general programme of work covering the period 1984-1989. 153pp.

WHO (1976) Reference material for health auxiliaries and their teachers (REMAHA). WHO Offset Pub. No. 28. Eng. Fr.
An annotated bibliography for use by teachers and administrators. It is being updated.

* WHO (1980) Towards a better future, maternal and child health.

10.3. Putting mother and child care plans into action

See also the following Sections of this bibliography:

- 1.1.5.2. Organisation of antenatal care;
- 1.2.6.2. Organisation of delivery care;
- 1.3.3. Planning, organisation and evaluation of postnatal services;
- 2.2. How can child nutrition problems be tackled?;
- 4.3.2. Providing and evaluating birth spacing/family planning services;
- 5.3. Avoiding the problems of spoiled vaccines and improving the cold chain;
- 6.13. Planning, organising and evaluating environmental health services.

* Abbatt, F.R., Jonsson, R.J. and Martin, J.D. (1982) Manual for training district level staff in the planning and management of health care in Zambia. Trainer's manual and learner's manual. These very useful manuals include exercises and case studies e.g. tasks and responsibilities of the district medical office, how are meetings conducted?; personality roles in the management team;

allocating tasks; identifying health problems and setting priorities; preparing a project plan; costing a plan (immunisation); evaluation and monitoring. There are also notes on educational methods (brainstorming, snowballs, syndicate groups, leading a small group discussion, using charts and overhead projectors and evaluating workshops).

APHA (American Public Health Association) (1982) Primary health care issues: Community financing.

APHA (American Public Health Association) (1977) The state of the art of delivery of low cost health care in developing countries.

A summary study of 180 health projects.

* **Amonoo-Lartson, R., Ebrahim, G.J. Lovel, H. and Ranken, J. (1984)** District health care. Challenges for planning, organisation and evaluation in developing countries. See particularly Chapter 4: Putting the plan into action.

* **Angola, Ministry of Health (1981)** 1. Organising an MCH clinic. 2. How to run a health team. (3. Primary child care: translation of M.King et al.) Port. only, mimeo.

Colgate, S.H., et al. (1979) The nurse and community health in Africa.

Relevant sections include: why work as a team?; the objectives of the health team; the nurse and the formation of a village health committee; organisation of the outpatient clinic; the importance of outpatient clinic statistics; how the nurse helps the laboratory technician; managing the pharmacy; how the nurse implements plans for school health; health planning and administration at the health centre level.

* **Conference of Missionary Societies (1975)** A model health centre.

A very practical book intended for a unit serving a population of about 20,000 people.

* **Ebrahim, G.J. (1976)** A model of integrated community health care. Simavi essay. Trop. Geog. Med. 28: pp.550-552.

* **Ghana, Ministry of Health (1980)** District health training manual series.

An excellent series but it may be difficult to obtain.

Health Education Council, UK (1979) Looking after yourself. An illustrated booklet with pictures, showing a 10-point action plan to better health:

1. getting started - choose activities you really enjoy.
2. make it regular - preferably three times a week.
3. keep it up at least 15 minutes a time.
4. start gently and increase the effort gradually.
5. get family or friends to join you.
6. keep a watch on your weight - stay slim.
7. cut down fatty foods - especially dairy products and meat.
8. steady on the sugar and sweet things.

9. eat more fibre - like brown or wholemeal bread, fruit, cereals, and potatoes.
10. get started - now.

The booklet addresses itself to the UK public, but could be of some use to others.

* **Indonesia, Directorate General of Community Health** (1976) Health centre reference manual, Vol. 1.

See particularly the sections on the administration and management of health education, nutrition, hygiene and sanitation.

* **International Children's Centre**, (1980) Infant nurseries and day care.

Includes leaflets for mass media specialists; academic level workers and professionals; policy makers; and nurses, midwives, social workers, teachers and parents.

International Labour Organisation, Geneva:

1. (1978) Structure and functions of rural workers' organisations, a workers' education manual.
2. (1979) Man in his working environment, a workers' education manual.
3. (1980) Standards and policy statements of special interest to women workers.
4. (1979) An ABC for public relations officers in trade unions.
5. (1978) Special services of rural workers' organisations, a workers' education manual.
6. (no date) The ILO and the world of work.
7. Filmstrips:
 - * The role of trade unions in family welfare.
 - * The trade union and the worker's family.
 - * Using leisure creatively.
 - * Making work more human.
 - * Somewhere to live.
 - * Your role as a shop steward.
 - * ILO's technical cooperation programme.
 - * The story of ILO.
 - * The world in which we live.
8. (1979) Getting together; a workers' education visual aid kit for use among Asian rural workers.

International Women's Tribune Centre Inc. (quarterly) Newsletter.

Includes items on appropriate technology for women, e.g. farming, grinding, shelling, marketing, food, fuel, and water carrying.

McGrath, E.H. (1978) Basic managerial skills for all.

Includes: "How to read" (the secret of reading lies in thinking with questions); how to learn more efficiently; how to talk (structure it); how to listen (do you think listening is easy?); how to become the real you; how to run a meeting; how to teach and train; how to manage (change, leadership and decision making, motivation, conflict and cooperation).

* **Management Sciences for Health** (1974) Problem action guidelines for basic health care: a tool for extending effective services through auxiliary health workers.

A series of useful flow charts for learning and reference

particularly for history taking examination, and treatment procedures.

Maneno, J., Schluter, P., Sjoedsma, A.C., Vogel, L.C. and Savage King, F. (1982) Guidelines for the management of hospital outpatient services.

Topics include: SOS short of staff; SOS short of space; OOS, out of stock; human problems; prescribing, preparing and dispensing drugs. The book is clearly written with many amusing illustrations and useful questions, e.g. Do more staff automatically give more time to their patients? How can you make sure that the extra staff are an advantage? What are the causes of waiting? (Look at where patients wait; look at when patients wait; try to decide why patients wait in that place at that time).



Fig 2-4. Do more staff automatically give more time to their patients?

Fig. 10.17.



Fig 2-5. What do people without enough work sometimes do?

Fig. 10.18.

PAHO/WHO (1982) Preparation of health services personnel in primary health care with emphasis on maternal and child health. Working guide, guidelines for adaptation, guidelines for community based training. Experimental edition.

* Papua New Guinea, Dept. of Public Health (1975) Family planning for aid-post orderlies and nurse aides. 35pp.
P.33: Family planning record card.

FAMILY PLANNING RECORD CARD															
<p>Aid post <i>Yagang</i></p> <p>Card number <i>15</i></p> <p>Woman's name .. <i>Mary Ihu</i></p> <p>Woman's age <i>25</i></p> <p>Husband's name .. <i>John Tali</i></p> <p>Place (living now) .. <i>Yagang</i></p> <p>Place where born .. <i>Hohola, N.C.P.</i></p> <p>No. of children - living .. <i>2</i></p> <p>No. of children - dead <i>0</i></p> <p>Birth date of youngest .. <i>15.5.74</i></p> <p>Date of last menstrual period <i>...none since birth of baby...</i></p> <p>Treatment .. <i>1 packet Microlut</i></p> <p>Date today <i>4.11.74</i></p> <p>Date to come back .. <i>25.11.74</i></p> <p>Name of APO ... <i>A. Bara</i></p>	<p style="text-align: center;"><u>Check List for Pills</u></p> <p style="text-align: right;">Write "yes" or "no"</p> <table style="width: 100%;"> <tr> <td style="width: 80%;">1. Have you had yellow eyes or yellow skin in the last year? (Look at her skin and eyes to see if they are yellow now).</td> <td style="width: 20%; text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>2. Have you a lump in the breast?</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>3. Have you blood stained discharge from your breast?</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>4. Do you have bad headaches?</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>5. Have you got big veins in your legs? (Look at her legs to see if she has <u>bad</u> varicose veins).</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>6. Do you lose too much blood with your menstrual periods?</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> <tr> <td>7. Do your menstrual periods come too often?</td> <td style="text-align: center; border: 1px solid black;">no</td> </tr> </table> <p style="margin-top: 10px;">If she is breastfeeding a baby less than 12 months old - give Microlut.</p> <p style="margin-top: 5px;">If not - give Eugynon ED Fe.</p>	1. Have you had yellow eyes or yellow skin in the last year? (Look at her skin and eyes to see if they are yellow now).	no	2. Have you a lump in the breast?	no	3. Have you blood stained discharge from your breast?	no	4. Do you have bad headaches?	no	5. Have you got big veins in your legs? (Look at her legs to see if she has <u>bad</u> varicose veins).	no	6. Do you lose too much blood with your menstrual periods?	no	7. Do your menstrual periods come too often?	no
1. Have you had yellow eyes or yellow skin in the last year? (Look at her skin and eyes to see if they are yellow now).	no														
2. Have you a lump in the breast?	no														
3. Have you blood stained discharge from your breast?	no														
4. Do you have bad headaches?	no														
5. Have you got big veins in your legs? (Look at her legs to see if she has <u>bad</u> varicose veins).	no														
6. Do you lose too much blood with your menstrual periods?	no														
7. Do your menstrual periods come too often?	no														

The other side is for follow-up visits:-

Date of visit	Date of last menstrual period	Any problems?	Treatment	Date of next visit
25.11.74	not yet	—	3 packets Microlut	17.2.75
17.2.75	8.2.75	—	3 pack. Microlut	12.5.75
12.5.75	5.5.75	—	3 packets Eugynon ED Fe	4.8.75
4.8.75	1.8.75	—	3 packets Eugynon ED Fe	27.10.75

Fig. 10.19.

* Papua New Guinea, Ministry of Public Health (1979) Standard treatments for common illnesses of children in Papua New Guinea; a manual for nurses, health extension officers and doctors. 2nd edition. 66pp.

A useful compact notebook-sized manual for easy reference.

* Philippines, Rural Missionaries (1976) Go to the people, live with them, learn from them, love them, start with what they know, build on what they have. Diocesan community based health programmes, 1976 workshop recommendations.

Rifkin, S.B. (ed.) (1977) Community health in Asia; a report on two workshops.

Describes community involvement in health care in Indonesia, Malaysia, Sarawak, Philippines, India and Nepal.

Rohde, J.E. and Hendrata, L. (?1979) Development from below, transformation of village based nutrition projects to a national family nutrition programme in Indonesia. Mimeo. Reproduced In: Morley, D.C. and Williams, G. (1983) Practicing health for all.

Scheveser, H. (1972) A manual for health education in Botswana. 90pp.

* Scotney, N. (1976) Health education: a manual for medical assistants and other rural health workers. 141pp.

P.50: Table-taking times are shown by drawings of sun's position.

* Thailand, Ministry of Health (1981) Community health volunteers' nutrition and health work manuals I-VI.

UNICEF (1981) Appropriate technology for primary child care. By Haxton, D.P.

US, Center for Disease Control (1981) R. and D. Feedback, Newsletter.

"Four keys areas to improve the motivation of health staff:

Questions

- | | | |
|----|------------------------------|---|
| 1. | Self image | <ul style="list-style-type: none"> a. Is my job important? b. Am I important? c. Do people care if I do a good job? d. If I do a good job, will it be recognised? |
| 2. | Authority and responsibility | <ul style="list-style-type: none"> a. Considering the responsibility I am entrusted with, do I have the authority to improve the programme? b. Am I managing my work, or am I a cog in a big machine? |
| 3. | Positive supervision | <ul style="list-style-type: none"> a. Am I respected by my supervisor? |

- b. Is good work recognised?
- c. When I have problems or make errors, does my supervisor help me solve them in a constructive way?
- d. Does my supervisor provide continuing education to help me do a better job?

4. Feedback

- a. Does anyone care what I do?
- b. Are my reports read?
- c. Is action being taken on my requests?
- d. Is good work recognised in a formal way?
- e. What feedback do I receive?

As we begin to measure progress toward our objectives in improving health; we recognise our limitations in the above four areas. Improvement will require intensive effort through training, supervision, continuing education and feedback."

VHAI (1978) Teaching village health workers, a guide to the process; teaching pack.

The pack includes a small illustrated book on planning teaching for village health workers, and a second small book on lesson plans. Inside a locally produced folder are examples of a dice game for teaching, flashcards, a puppet play, slides, illustrations for posters and shapes for a flannelgraph. Book 1 starts with the personal story of a village health worker in India: how she came to begin her work, her feelings during the training and the work she does now. Photographs supplement the words throughout the material. Topics covered in the lesson plans include dehydration with diarrhoea, burns, wounds and cuts, breastmilk, supplementary foods for infants, nutrition teaching for pregnant women, danger signs in pregnancy, family planning, prevention of blindness.

* VHAI (1975) Village health workers for basic health care. Includes: What is a village health worker? Why have them? Explains their financing, selection, training, support and guidance, programme of work.

* Werner, D. (1977) The village health worker, lackey or liberator?

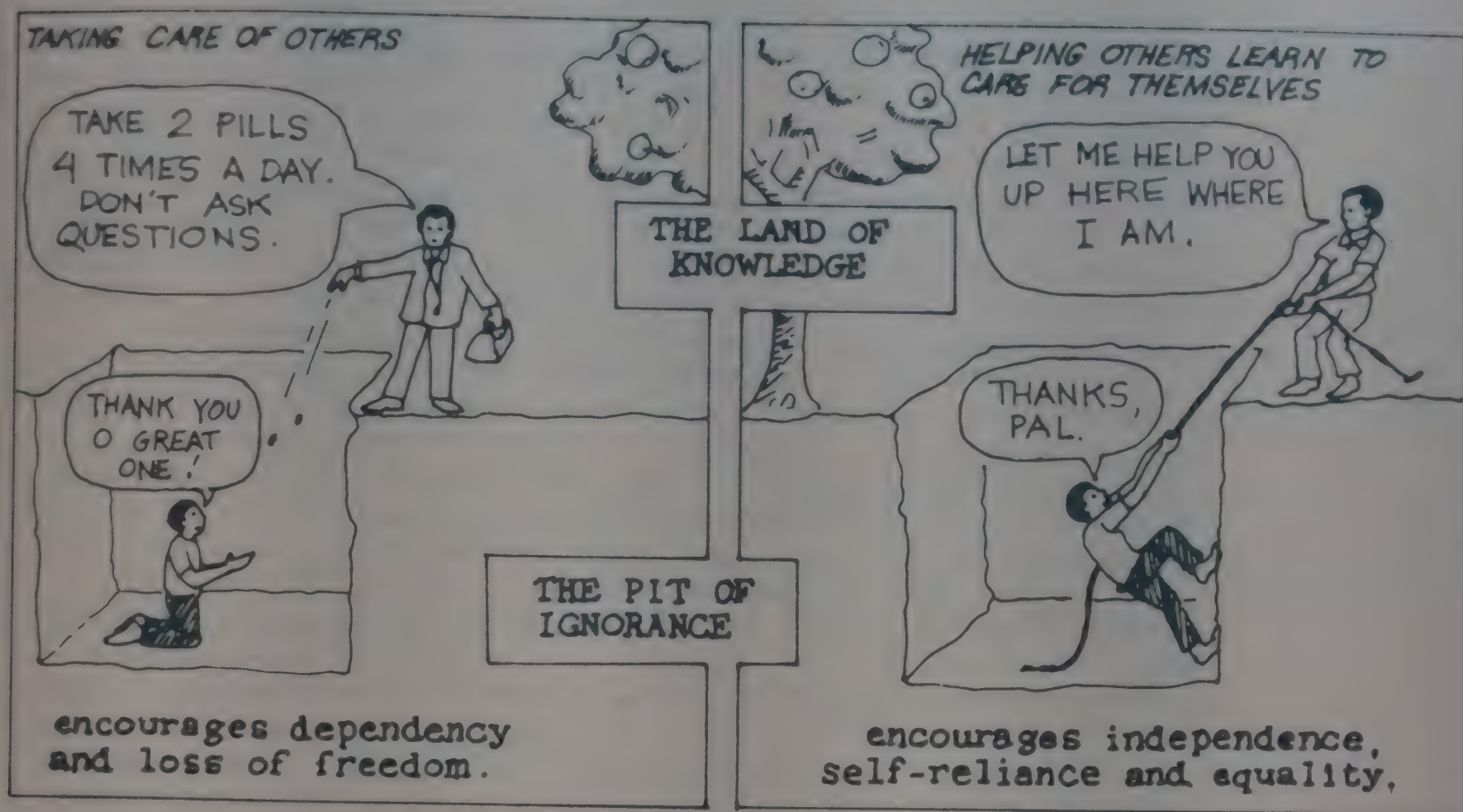


Fig. 10.20: Two approaches to health care.

* Werner, D. (1977) Where there is no doctor.

P.W27: Discusses the causes of child diseases, with an example of a picture starting-point for discussion "What can you see that may have caused the child to become sick?" (rat, human faeces, dirty milk, feeding bottle, large family man drinking alcohol, poor nutrition, spread of infection, etc.).

P.63: Tablet size (whole, half or quarter) is shown in picture form with the time of day it is to be taken: morning (sunrise), midday (sun high), evening (sunset) or night (moon). Also shows eight pictorial symbols that would be useful in record keeping. In record keeping, the key words should be kept simple, to record only what is needed to fulfil the objectives of the local community.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Chapter 26, p.12:

"Why is it that so many people "just don't seem to care" about changing or improving their situation?"

What can I do to help people awaken to their own possibilities? To help health workers answer these questions, it may be useful to discuss the following 'stages of awareness'. These are based on the ideas of Paulo Freire, the Brazilian educator. Freire's methods for the development of 'critical awareness' became widely used in Brazil as a part of literacy programmes After the military coup in 1964, however, Freire was jailed and later thrown out of the country. Freire describes 3 main stages of awareness.

1. Magic awareness. At this stage, people explain the events and forces that shape their lives in terms of myths, magic, or powers

beyond their understanding and control. They tend to be fatalistic, passively accepting whatever happens to them as fate or 'God's will'. Usually they blame no one for the hardships and abuses they suffer. Although their problems are great - poor health, poverty, lack of work etc. - they commonly deny them. They are exploited, but are at the same time dependent upon those with authority or power, whom they fear and try to please. They conform to the image of themselves given to them by those on top. They consider themselves inferior, unable to master the skills and ideas of persons they believe are 'better' than themselves.

2. Naive awareness. A person who is naive has incomplete understanding. Persons at the naive stage of awareness no longer passively accept the hardships of being 'on the bottom'. Rather, they try to adapt so as to make the best of the situation in which they find themselves. However, they continue to accept the values, rules, and social order defined by those on top (authorities, big landholders, etc.). In fact, they try to imitate those on top as much as possible. For example, they may adopt the clothing, hair styles, and language of outsiders, or choose to bottle feed rather than breastfeed their babies. At the same time, they tend to reject or look down upon their own people's customs and beliefs. Like those on top, they blame the hardships of the poor on their ignorance and 'lack of ambition'. They make no attempt to examine critically or to change the social order.

3. Critical awareness. As persons begin to develop critical awareness, they look more carefully at the causes of poverty and other human problems. They try to explain things more through observation and reason than through myth or magic. They start to question the values, rules, and expectations passed down by those in control. They discover that not individuals, but the social system itself, is responsible for inequality, injustice and suffering. They find that it is set up to favour the few at the expense of the many, yet they see that those in power are in some ways also weak, and are also 'dehumanised' by the system. Critically aware persons come to realise that only by changing the norms and procedures of organised society can the most serious ills of both the rich and the poor be corrected. As their awareness deepens, these persons also begin to feel better about themselves. They take new pride in their origins and traditions. Yet they are self-critical and flexible. They do not reject either the old or the new, but try to preserve from each what is of value. As their self-confidence grows, they begin to work with others to change what is unhealthy in the social system. Their observations and critical reasoning lead them to positive action."

* Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981) Community health.

Relevant sections include: the organisation of health services; and administration of health centres and dispensaries.

World Food Programme (1979) Women in food for work, the Bangladesh experience.

WHO (1981) Managerial process for national health development. Guiding principles for use in support of strategies for Health for

All by the Year 2000. Health for All series; No.5. 61pp.
A broad but useful account. For the full series, see Section 10.2.

10.3.1. Organisation applicable to all schemes

10.3.1.1. Organisation of supplies

Indonesia, Directorate General of Community Health (1976)
Health centre reference manual. Vol.I.

Pp. 1/V111/1 - 1/V111/13: Describes many kits for use in health centres.

P. 1/V111/14: Includes excellent illustrations of tools for hygiene work - much more useful than copious listings.

P. 1/V111/4: A "housekeeping checklist which could be useful for supervising any building where a clinic takes place or health equipment is used.

10.3.1.2. Staff development

Indonesia, Directorate General of Community Health (1976)
Health centre reference manual. Vol.I.

P. 1/V11/2: Lists methods which can be used for staff development: individual patient conference, staff group conference, inservice training, evaluation procedures. This is a rather brief listing and would need expanding before it could be used for teaching.

10.4. Monitoring progress on provision of mother and child health care




See also bibliography Section as follows:












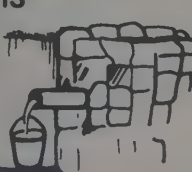






- 1.1.5.3. Evaluation of antenatal care;
- 1.2.6.3. Evaluation of delivery care;
- 1.3.3. Planning organisation and evaluation of postnatal services;
- 2.3. Evaluating nutrition teaching and nutrition intervention programmes;
- 4.3.2. Providing and evaluating birth spacing/family planning services;
- 6.13. Evaluating environmental health services;
- 11.14. How can training programmes for health personnel be evaluated?

* AMREF (?1979) Health happenings. Illustrated tally sheet.
Very useful.

HEALTH HAPPENINGS

Recorded by (CHW) _____ at (Community) _____

This is a record of things which you have seen to happen. The happening may be good or bad. For each happening make a mark like this  in the proper place. When your leader visits you, together count the  s and write the total and date of counting. Also you make a line like this  through all those you have just counted. Then they will not be counted twice. This paper will give your work acCOUNTability.

What you have seen new	Cases 	Total/date	What you have seen new	Cases 	Total/date
1  Newly PREGNANT woman	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		9  New DEATH under 1yr of age	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
2  DELIVERY assisted	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		10  New child ACCIDENT < 5 years	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
3  BIRTH	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		11  New or improved GRANARY	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
4  Birth ≤ 2 YEARS AFTER previous	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		12  Personal first HOME VISIT	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
5  New BCG scar	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		13  Group PROJECT completed	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
6  Newly MAL-NOURISHED (by scale / arm)	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		14  Newly improved COOKING place	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
7  New attack of DIARRHOEA in child < 5	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		15  New EYE problem any age	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	
8  Too SOON OFF BREAST (before walking)	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>		16  General public BARAZA meeting	<div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div> <div>○○○○○ ○○○○○</div>	

FROM THE COMMUNITY HEALTH WORKER SUPPORT UNIT AT AMREF

Fig. 10.21: The health happenings tally sheet from AMREF.

American Council of Voluntary Agencies for Foreign Service Inc. (1978) Approaches to appropriate evaluation.

* Clarke, N. and McCaffery, J. (1979) Demystifying evaluation: training programme staff in assessment of community based programmes through a field operational seminar.

* Cunningham, N. (1969) An evaluation of an auxiliary based child health service in rural Nigeria. J. Soc. Health, Nigeria 3 (3): pp.21-25.

The measurement of infant mortality, growth, surviving children and desired family size.

* Feuerstein, M.T. (1978) Evaluation by the people. International Nursing Review 25 (5): pp.146-153..
A useful article on the experience of a project in rural Honduras.

* Indonesia, Directorate General of Community Health (1976) Health centre reference manual, Vol.IV: Section on recording and reporting.

* King, M., King, F. and Martodipoero, S. (1979) Primary child care, a manual for health workers. Book 2.
Chapter 4: Some more instruments for evaluation. Surveys, coverage of care, checklists, observation in the clinic etc. are discussed.

* Lovel, H.J. (1980) Flow chart for an epidemiological investigation. MSc in mother and child health prospectus.

Fig. 12 FLOW CHART FOR AN EPIDEMIOLOGICAL INVESTIGATION

Lovel, H.J. (1980) Institute of Child Health, London WC1N 1EH

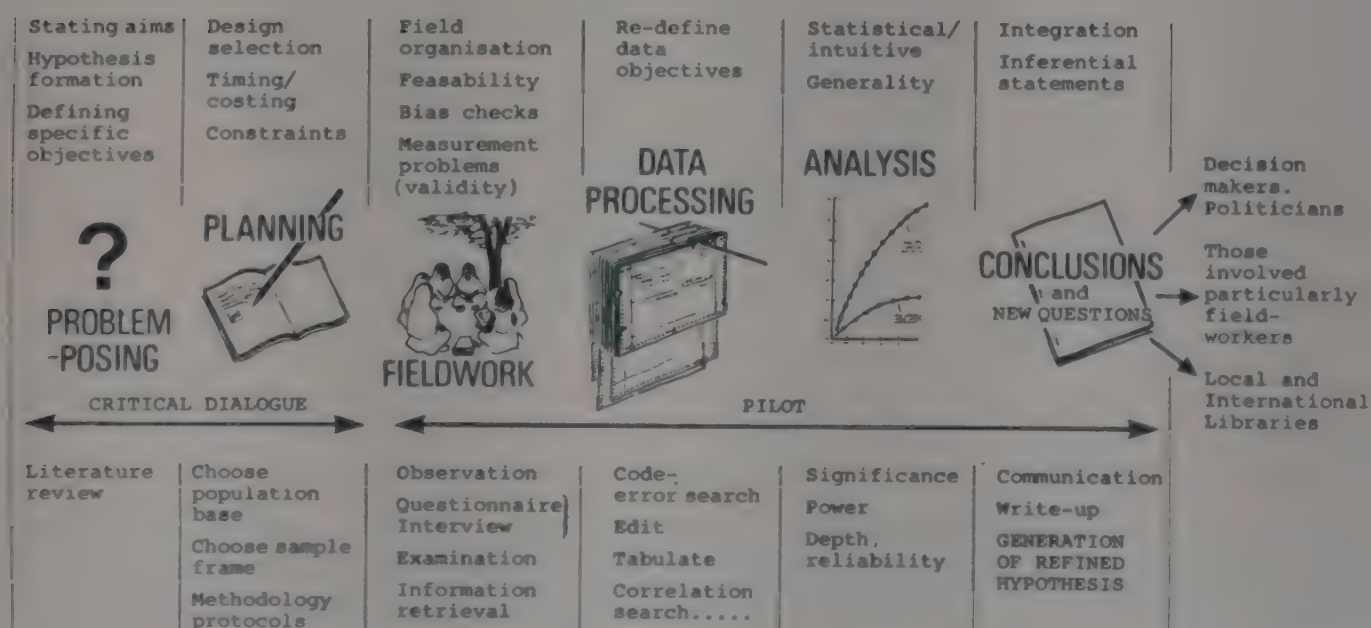


Fig. 10.22: Source TCHU. This picture may be reproduced.

* McCusker, J. (1978) Epidemiology in community health. A self-teaching manual for rural health workers.
See particularly Chapter 8; Evaluating community health services.

if, after teaching, students can now see the reasons why a child may become sick (human faeces, alcoholism, poverty, dirty feeding bottle, too many pregnancies in the mother, etc.)
See the picture in this bibliography, Section 10.1, Fig. 10.2.

Wignaraja, M. (1978) Frameworks of development and implications for project design and evaluation.

Chart IV: The criteria for project evaluation are described. These include the gaining of experience in management, material benefits, transfer of political power, reduced conflicts, reduced dependence, innovations, and links with other villages.

Illustrative criteria for project evaluation

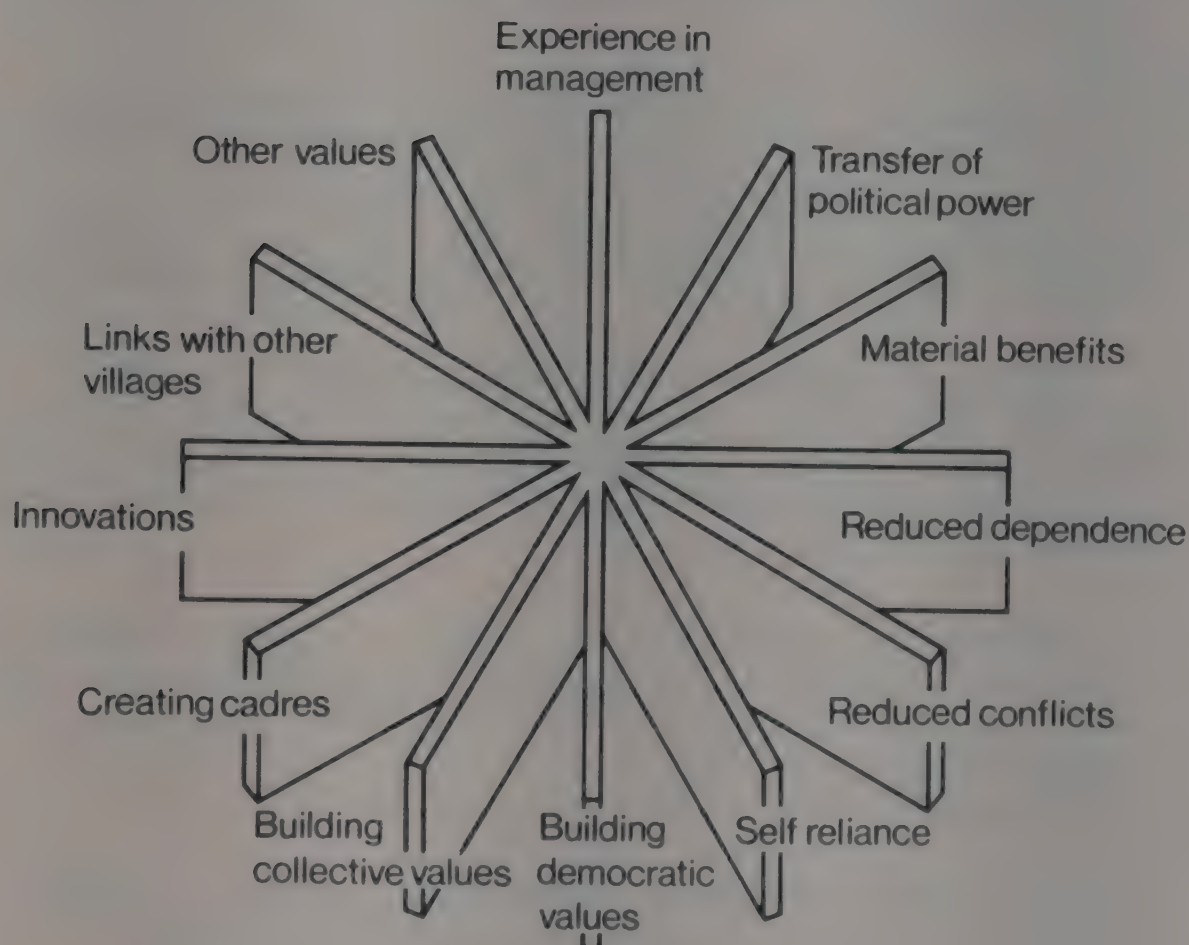


Fig. 10.25.

* **World Bank (1979)** Health sector policy paper.

Includes useful indicators of disease and health patterns. The coverage and effectiveness of health programmes are also tackled.

* **WHO Health for All series.** Eng. Fr. Sp. Arabic. Chinese. Russian.

No.4. (1981) Development of indicators for monitoring programs towards Health for All by the year 200. 91pp.

No.6. (1981) Health programme evaluation. Guiding principles for its application in the managerial process for national health development. 47pp.

For the whole series, see Section 10.2. of this bibliography.

Learning to work with local services (health and other) and local groups involved in community development

Alaska, Bureau of Environmental Health (1959) A sanitation guide for Alaskan sanitation aides.

Pp.54, 56-58: How you can help the supervisors and they you in working with the council: guidelines.

* Bradley, D.J. (1977) Water; the hidden dangers. World Health (January): pp.12-16.

Emphasises the necessity of liaison with other agencies; points out that health problems may follow water development unless preventive public health actions are taken.

Dupin, H. and Dupin, M. (1965) Our foods; a handbook for educationlists in West Africa.

Discusses liaison with schools and schoolteachers, and suggests obtaining information on what schools may be doing and teaching about nutrition.

* Indonesia, National Workshop on Dukuns and Family Planning (1972) The role of the traditional midwife in the family planning programme; a workshop to review research.

Pp.37-39: Suggests problems that may arise between Dukun family planning workers and other family planning health workers.

* Madang Paramedical Training College (no date) Information on the training of health extension officers and health inspectors at Madang Paramedical College, Papua New Guinea.

A useful example of how other people's jobs can be described briefly and interestingly.

* Markie, J. and Perl, S. (eds.) (1977) Common concern; a guide to collaboration between co-operatives and family planning associations. Education for population awareness and responsible parenthood. Eng. Fr. Sp.

Describes liaison with co-operatives.

Sudan, Family Planning Association (1975) A family planning survey of Arbaji village in Gezira area, Sudan.

Community development promoters already work in the Gezira area and have established adult education and social welfare services. The Sudan Family Planning Association has recommended that these adult educators might be employed very fruitfully in spreading knowledge of the family planning services and the places where information can be obtained.

US, Dept. of Agriculture (1971) Homemaking handbook for village workers in many countries. 237pp.

P.24 includes excellent photographs.

Pp.25-38 discuss liaison with other agencies.

* Werner, D. (1977) Where there is no doctor.

Describes methods of liaison: working and learning together through village health committees; group discussions, work festivals, co-operatives, classroom visits, mother and child health meetings. Suggests liaison with chiefs about nutrition education.

P.W.24: Children will do an amazing amount of work when it is turned into a game! (Illustration).

Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981)
Community health.

Chapter 1: Introduction of community health. The basic tenets of community health are explained: prevention, education, services, coverage, risk groups, organisation of primary and basic health care, community diagnosis.

World Education (1971) The Esfahan seminar.
Report of a regional seminar on functional literacy and family planning education.

World Education (1975) Literacy and family planning.
Liaison with literacy programmes.

* WHO, Regional Office for South-East Asia (1973) Notes for the practising midwife.

The essential role of the midwife in community development and liaison between agencies is described. She can establish connections with hospitals, maternal and child health clinics, vaccination centres, medico-social workers, health officers, registrars, medical practitioners, special clinics, voluntary societies, community health centres, sanitary officers, headmen, traditional birth attendants, creches, etc.

Pp.8-11: Community development - the role of the midwife.

Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (no date) L'education de la sante a l'ecole. Booklet 5.

Notes

Notes

11. Learning how to teach others to provide better MCH care.



11. Learning how to teach others to provide better MCH care.

11.1. What is the teaching - learning process?

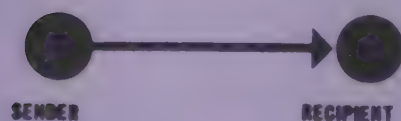
11.1.1. What is communication? When does it fail?

* Colle, R.D. and Colle, S.F. (1981) The communication factor in health and nutrition programmes: a case study from Guatemala, and an audio-tape for teaching at the "Pila" in Guatemala.

* Fuglesang, A. (1982) About understanding-ideas and observations on cross-cultural communication. 231pp. Discusses models of communication. Explains perception as a "building up" of what we see. "Writing a book on cross cultural communication is like walking in the dark on a stony path. The problem is one of seeing. "Don't think - look!" Understanding is more a state of mind than a mental process - it is the state of seeing" "You people do not understand. Your words do not belong to our minds." (Old village woman, Zambia).

TWO SIMPLE MODELS

The typical attitude and the professional approach are reflected in a very simple model. "Experts", volunteers, local professionals, field workers of all categories, journalists, broadcasters, producers of educational films, educators - they all unthinkingly perform their function in development work as a one-way sending out of a message.



The sender is the one who is knowledgeable and the recipient is perceived as some kind of empty, passive barrel which has to be filled with the sender's knowledge. This is the frightening picture we find all over the world and by no means in developing countries only.

Information is poured out. Nobody really cares about what is happening to it.

It must be clear that communication cannot be a meaningful concept unless it is considered as an involvement in a two-way process, a circulating flow of

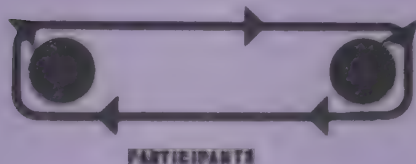


Fig. 11.1: Illustration taken from a previous book by Fuglesang: applied communication in developing countries; ideas and observations" (1973) No longer available.

Guilbert, J.J. (1981) Educational handbook for health personnel. WHO Offset Pub. No.35. Revised edition. Contains straightforward notes on the purpose of teaching: some principles of learning; methods of teaching; education as a process; purposes of evaluating teaching. There is a good diagram of the spiral phases of education: determining objectives, programme implementation, development of evaluation procedures.

* International Labour Organisation (ILO) (1977) The theory of communication (an instructional aid for beginner workers' education).

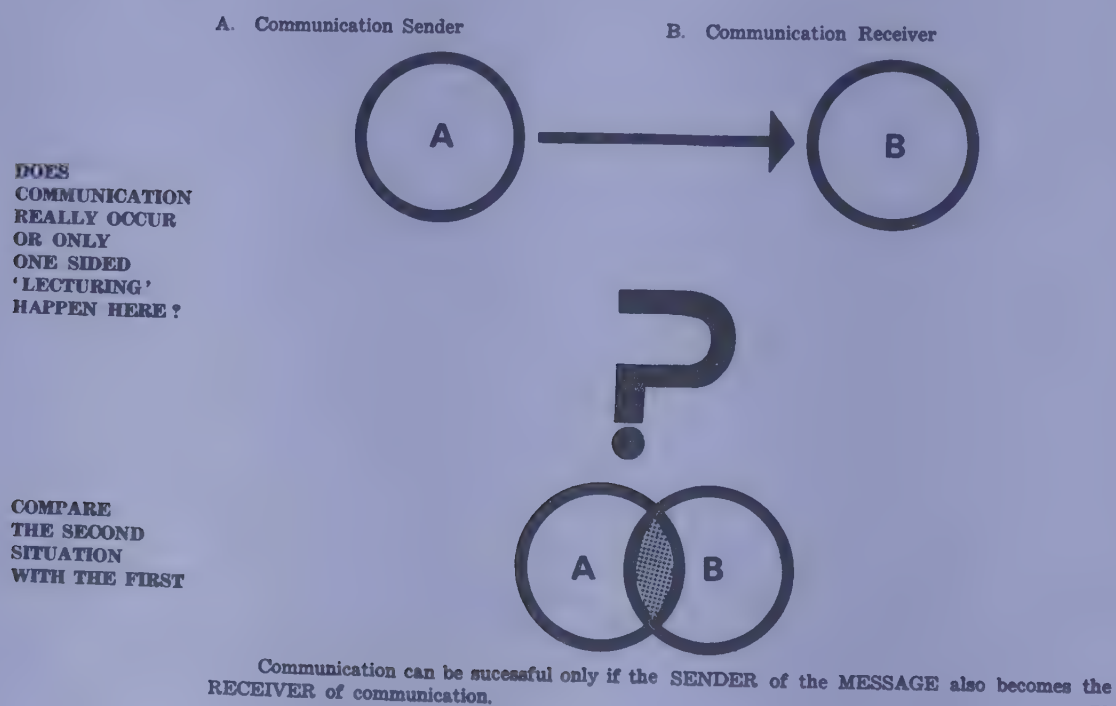
Morley, D.C. (1976) Communication in health. 24 slides with text. A cassette tape is also available. Methods of communication in health are examined, for instance, lectures are like "pushing out knowledge" and suffer from being one-way communications. Group discussion or seminar teaching has many advantages, because in them there is "pulling in knowledge" as well. Other techniques of communication are also discussed.

* Saunders, D.J. (1974) Visual communication handbook; teaching and learning using simple visual materials. Chapter 1: Asks the basic questions about communication: who is saying what to whom and how?

* Scotney, N. (1976) Health education; a manual for medical assistants and other rural health workers. Chapters 1, 2, 4,: What makes education succeed and fail; health and the behaviour of people; effective communication.

UNESCO (1977) Communication and rural development. A brief review of communications theory and rural development, followed by case studies from Colombia, Brazil, India, Senegal, Peru, Iran, Tanzania, Canada, Tobago, Philippines.

VHAI (1978) Teaching village health workers, a guide to the process; a teaching pack. Points out that communication can be successful only if the sender of the message also becomes the receiver of communication.



* Werner, D. (1977) Where there is no doctor.

P.W.19: Communication in health needs to educate people about the sensible and limited use of medicines. "When medicines are not needed take time to explain why".



WHEN MEDICINES ARE NOT NEEDED, TAKE TIME TO EXPLAIN WHY.

Fig. 11.3.

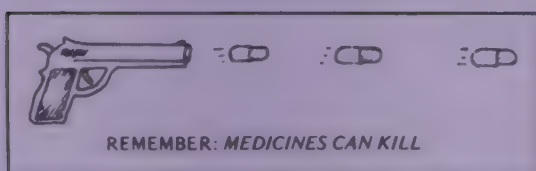


Fig. 11.4.

11.1.2.

How can learning sequences be structured?

* Abbatt, F.R. (1980) Teaching for better learning, a guide for teachers of primary health care staff.

* Bligh, D. (?1976) What's the use of lectures?

* Buzan, T. (?1982) Use your head?

Very useful methods for effective teaching/learning are described.

Guilbert, J.J. (1981) Educational handbook for health personnel. WHO Offset Pub. No.35. Revised edition. Contains useful summaries of: procedures for structuring learning, using objectives, how to organise a short educational workshop.

P.19: Illustrates the planning spiral - definition of objectives, programme implementation, evaluation.

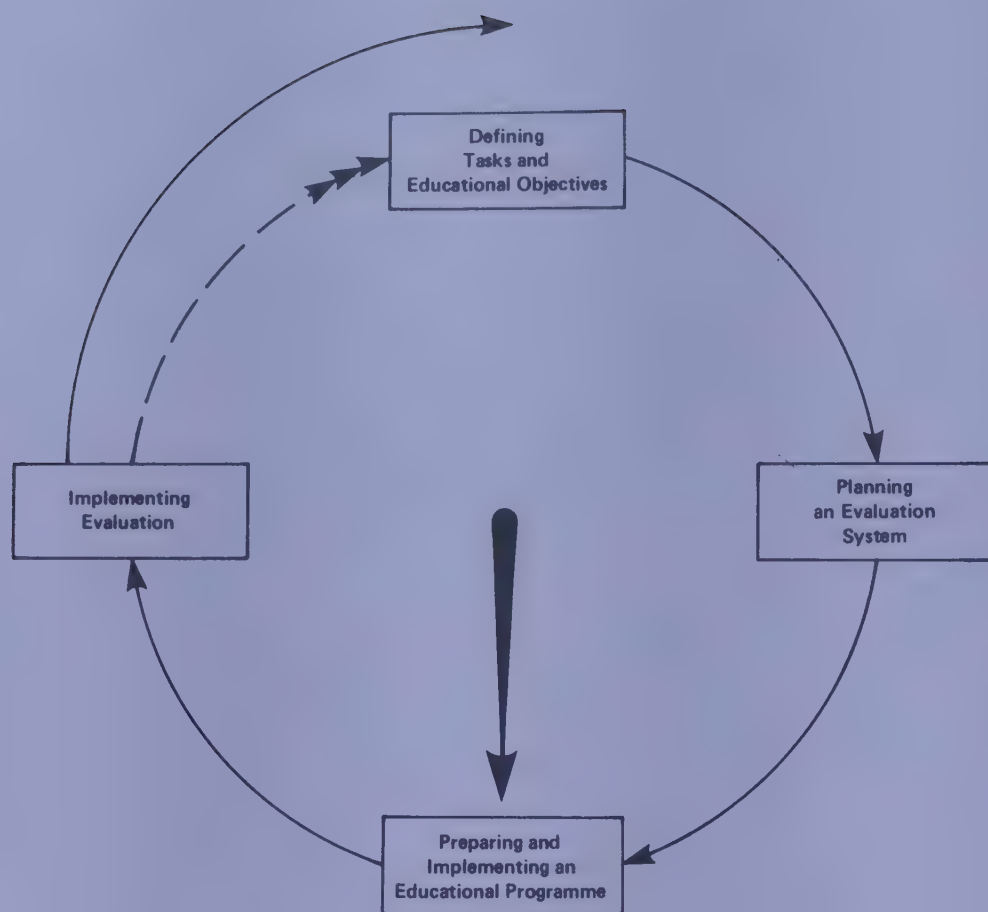


Fig. 11.5.

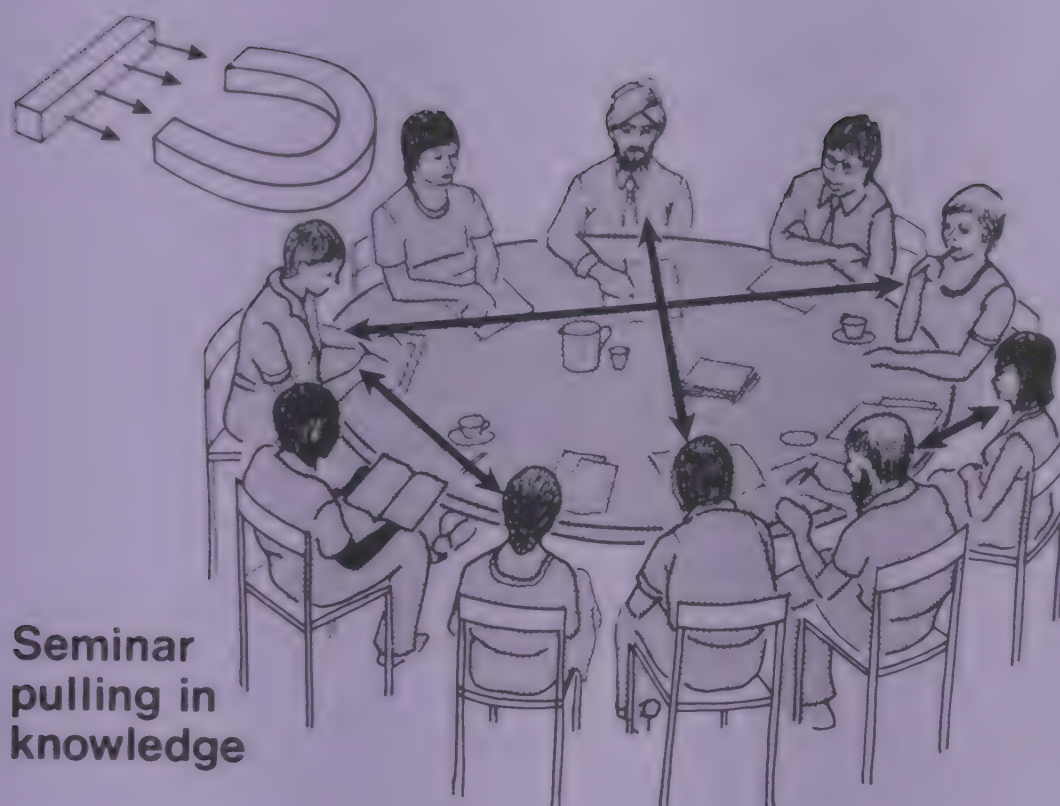
* Helander, E., Mendis, P., and Nelson, G. (1980) Training the disabled in the community, an experimental manual on rehabilitation and disability prevention for developing countries. DRP/80.1.Rev 2.

Teaching in this manual follows the structure of normal child development.

India, Ministry of Food and Agriculture (no date) Guide for the village worker.

Outlines four basic extension principles and gives 21 teaching methods for the best rural development results.

* Institute of Child Health, University of London (1982) MSc in Mother and child health prospectus.



**Seminar
pulling in
knowledge**

Fig. 11.6: During the course the emphasis is placed on seminar discussions rather than lectures.

International Labour Organisation (ILO) (1975) Definition des objectifs, elaboration d'un plan de leçon, elaboration des tests, definition de la population, structuration de la matière, evaluation/le contrôle dans l'enseignement. Fr.

Iran, Shiraz, Pahlavi University, Dept. Community Medicine (1976) Kavar village health worker project. 2nd edition. A source of information for planning training for community health workers. Includes an outline of behavioural objectives, the preparation of teaching material, theoretical training, practical training, the field work phase, and evaluation.

Kehrberg, N. (ed.) (1975) Ways to better health. (Primary upper elementary health education lesson plans). 29pp. Examples of lesson plans for schools, but they could be used at other levels as examples of how to draw up a simple lesson plan.

* Lovel, H.J. (1975) Teaching for effective learning. 24 slides with explanatory text. A cassette tape is also available. Some key procedures to make learning effective are described. These include getting learners to ask questions, and using keywords to remember ideas. Based on the book by Buzan, T. (?1982) Use your head?

* McCusker, J. (1978) Epidemiology in community health. A self-teaching manual for rural health workers. An example of material developed for self-instructional use. It is often helpful to use such material together with group discussions.

Mackenzie, N., Eraut, M. and Jones, H.C. (1970) Teaching and learning; an introduction to new methods and resources in higher

education.

Includes flow diagrams for: developing a teaching topic; course development and implementing a brief to teach something.

Madang Paramedical Training College (no date) Health extension officer's practical procedures book; 1st and 3rd years. Lists procedures which trainees must cover during their course, following the idea that if objectives are clearly stated teaching becomes simple. This is a useful booklet as an example of how obstetric, child health and immunisation procedures can be specified for a teaching programme.

Mager, R.F. (1962) Preparing instructional objectives. 61pp. Includes a story-line preface (2pp.) on why objectives are useful. P.6 carries an illustration and a useful summary on the same theme.

Mousseau-Gershman, Y. (1975) Manuel de travaux pratiques en sante communautaire, perspective interationale. A good example of the problem-solving-learning method (designed for nursing students).

* **Powell, L.S.** (1973) Lecturing. Pitman. No longer available.

"You may disapprove of lecturing as a means of communicating but sooner or later you will have to say something to someone and it can be said elegantly and efficiently or made to drift vaguely about and very, very boring".

* **TCHU** (1981) The cycle of undernutrition. Picture by Morley, D.C.

A good example of an illustration showing the relationships between factors affecting health.

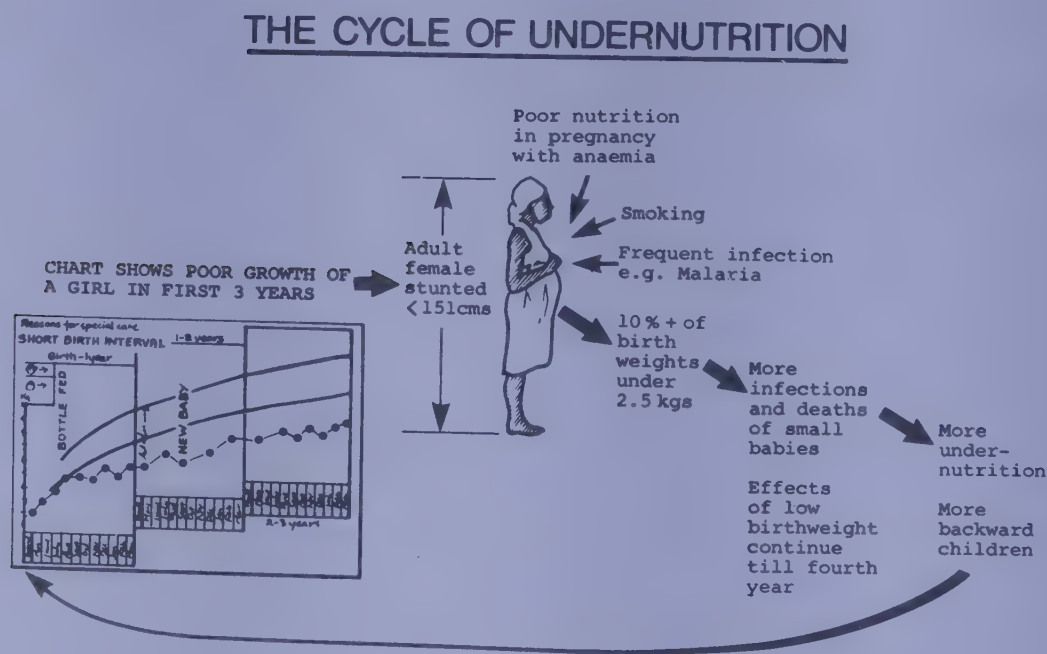
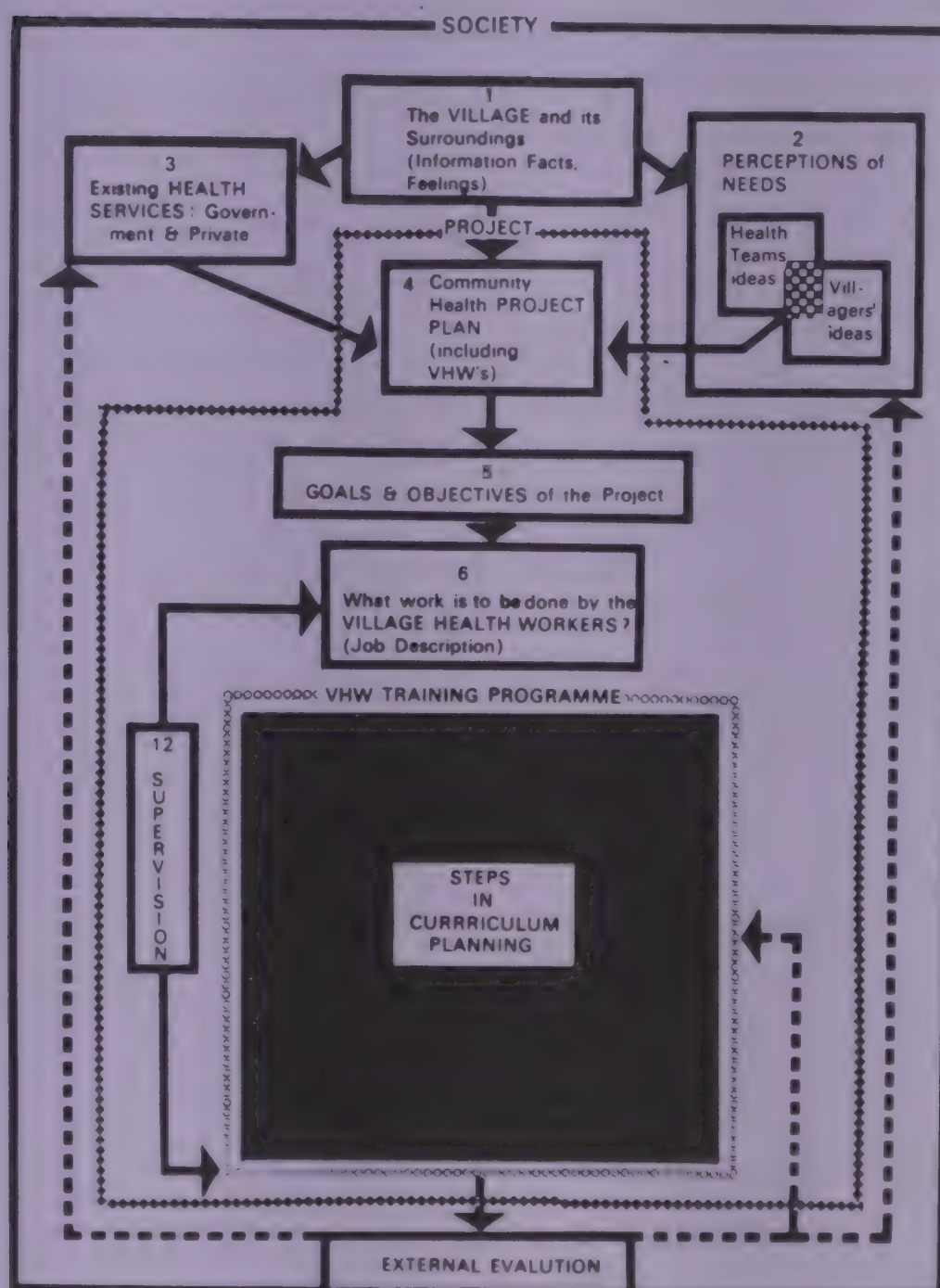


Fig.11.7.

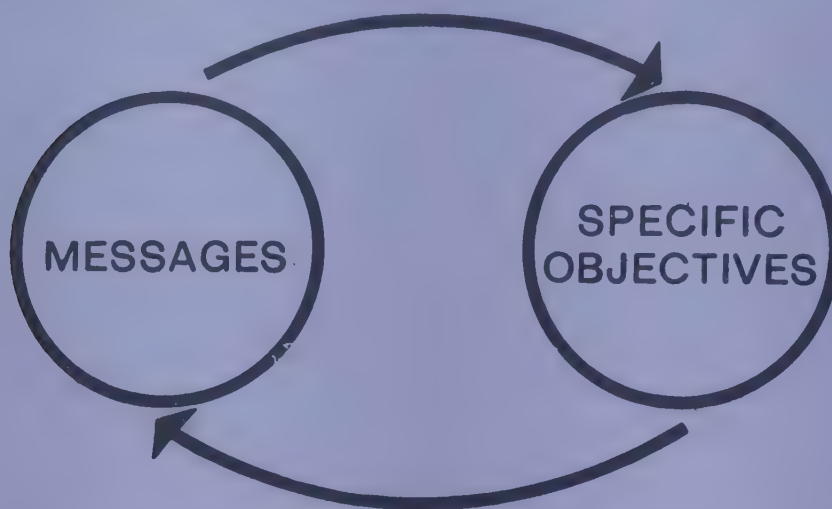
VHAI (1978) Teaching village health workers, a guide to the process; a teaching pack. Describes succinctly the need for defining "messages", i.e. specific objectives for village level workers to perform. Book 1 includes an outline of the steps in curriculum planning: fact finding about the local community; identifying needs perceived by villagers and local health teams; identifying existing health services, both government and private; developing a community health project; specifying goals and objects of the project; specifying work to be done by village health workers (job descriptions); training, evaluation and fact finding about the local community;..... and so it continues



Relationship between Society, Health Services, and teaching of VHWs Community Health project

Fig. 11.8.

The **MESSAGES** are the **ESSENTIAL KNOWLEDGE, ATTITUDES** and **SKILLS** which must be **COMMUNICATED** to the **VHWs** to make it possible for them to accomplish the **SPECIFIC OBJECTIVES**.

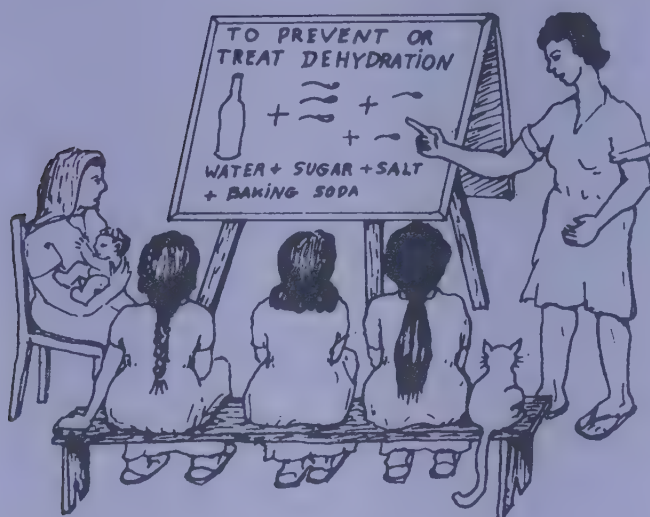


There is a **DIRECT RELATIONSHIP** between **MESSAGES** and **SPECIFIC OBJECTIVES**.

The Messages are limited to **ONLY** that material which the **VHWs** need. Remember also, that a Message is communicated or learned when the learner not only **knows** it, but has accepted and acts on the basis of the knowledge.

Fig. 11.9.

- * **Wakeford, R.E.** (1974) Teaching for effective learning; a short guide for teachers of health auxiliaries. 62pp.
An easy to read summary booklet which is useful for helping teachers to structure learning sequences and assess how well they did it.
See particularly pp.8-15: tasks and objectives; pp.16-21: planning teaching; pp.21-24:preparing lessons.
- * **Werner, D.** (1977) Where there is no doctor.
P.W.2: Part of the process of structuring learning is to look for opportunities to share knowledge with the people who most need it.



LOOK FOR WAYS TO SHARE YOUR KNOWLEDGE.

Fig. 11.10.

See also: Trying a new idea (manure) and its effects on crops: Fig. 2.27 in this bibliography.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

See especially Chapter 3: Planning a training programme.

* WHO/BLAT (1985, In press) Facilitating teaching-learning with modules. An approach for nurse midwife teachers. 2nd. revised edition.

Each module states what needs to be known, how to find out the necessary knowledge and skills, and how the learner can show that the objectives have been achieved. Sections are included on antenatal, intrapartum, postpartum and neonatal care and on family planning, etc.

11.1.3.

What is a problem diagnosis approach to teaching?

Afghanistan, Ministry of Public Health (1977) Basic health centre manual.

P.005: Problem index (e.g. breasts sore, see p.231; infertility, see p.245). An excellent example of problem to action guidelines.

Indonesia, Directorate General of Community Health (1976) Health centre reference manual, Vol.I.

There is a useful outline for planning a public health education programme, in Section 2 on health education. It could be useful for teaching trainers about a problem-diagnosis approach to teaching, although the pages are too closely typed for easy reading.

* Mayblin, W. (1977) Fever-action flow chart: Revision of: Management sciences for health: problem action guideline No.6. An example of an illustrated problem action flow chart: some of the pictures have been criticised as being ambiguous in some countries.

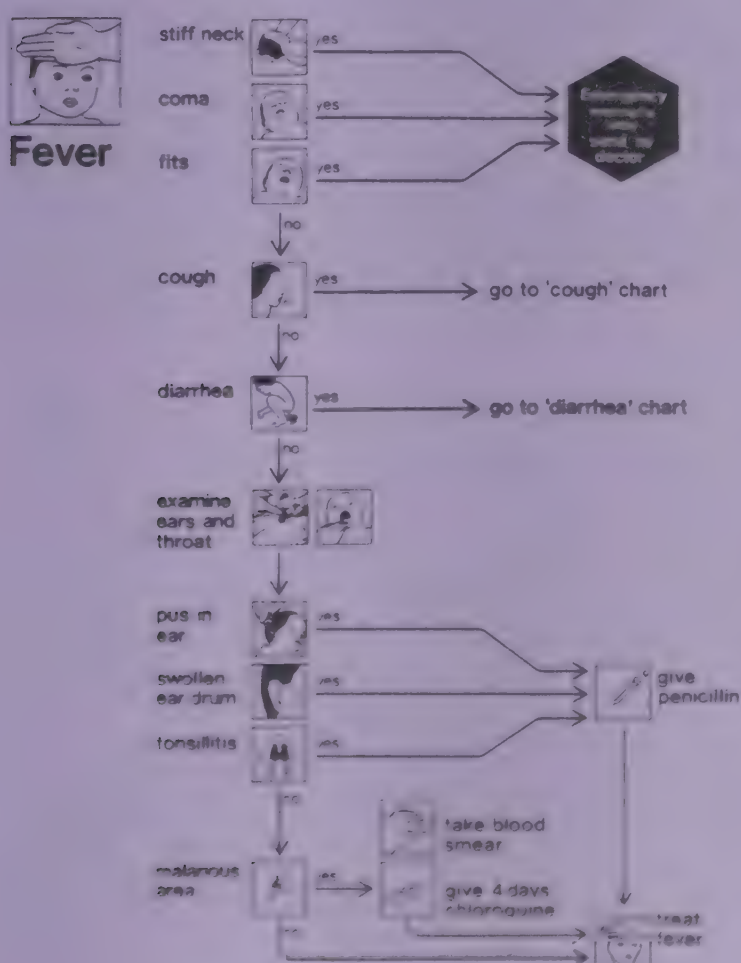


Fig. 11.11.

Peng, J.Y. et al. (1974) Role of traditional birth attendants in family planning: proceedings of an international seminar held in Bangkok and Kuala Lumpur 19-26 July 1974. IDRC-O39e. Pp.61-74: Problems found and lessons learnt.

* Werner, D. (1977) Where there is no doctor. P.W.26: Using pictures to get people talking about the causes of problems in the local community. Also suggests the questions and answers method e.g. pp.288-289: Questions and answers about birth control pills; see Fig. 4.18 in this bibliography.

11.1.4. **How can training programmes for health personnel be planned and evaulated?**

Katz, F.M. (1978) Guidelines for evaluating a training programme for health personnel. WHO Offset Pub. No.38. There are useful guidelines for the evaulation of training, although junior workers may need help at first to make best use of them. In practical everyday use, particularly important aspects of training evaluation include:

- (1) Finding out the jobs to be done at the end of training, the tasks they include and their responsibilities.
- (2) Finding out the training objectives and what tasks students are expected to be able to perform.
- (3) Finding out those personal characteristics of students which will help or hinder their work.
- (4) Finding out the resources available for training (staff salaries, transport, student grants, books, administrative support, places for teaching in the classroom and the community, and opportunities for inservice follow up).
- (5) Finding out the training processes from the staff and students' points of view (role models, incentives, priorities in practice as well as in theory).
- (6) Finding out the effects of the programme, both the intended effects on tasks performed (during training, at the end of training, and in the work situation), and the unintended effects (e.g. the attraction of unsuitable students to the course, compulsive concentration on terminology in training, creating anxiety in mothers, or creating conflict between them and other family members).

	During training	At the end of initial training	In the work situation
Intended effect	Knows basic principles of infant nutrition	In interview with a mother demonst- rates skills in giving advice on nutrition	Meets regularly with village mothers and provides advice on nutrition
Uninten- ed effect	Concentrates compulsively on terminology	Causes anxiety in mother about her competence in child care	Creates conflict between mothers and other family members

(7) Preparation of a summary of the qualities and achievements of the training, its problems and difficulties, and options available for its improvement.

* Rotem, A. and Abbatt, F. (1982) Self-assessment for teachers of health workers: How to be a better teacher. WHO Offset Pub. No.68.

See Chapter 9: Evaluation instruments.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Part 1 of the book looks at approaches to planning and carrying out a training programme for community health workers. Chapter 1 includes a useful exploration of alternative approaches to learning and teaching and what people learn explicitly and implicitly from different types of teaching methods. Chapter 2 is about the selection of both health workers and instructors and why experienced village health workers, first selected for training by their communities, later make the best instructors for new health workers. Chapter 3 considers the steps in planning a training course and Chapter 4 how to get it off to a good start. Then activities in the three main places for teaching are considered: the classroom (Chapter 5), the community (Chapters 6 and 7) and the clinic or health centre (Chapter 8). In all these situations the most effective form of learning is through actual practice in solving common problems. Chapter 9 discusses ways of finding out how well people are teaching, learning and meeting local needs. Chapter 10 considers what happens after the initial training course is completed and the health workers are back in their own communities, including supportive follow up and continued opportunities to learn.

Part 2 of the book examines learning through seeing, doing and thinking. It includes making and using teaching aids and pictures, story telling, role playing and solving problems step by step.

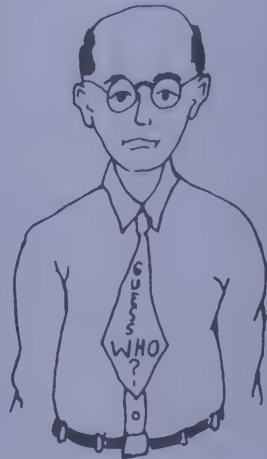
Part 3 covers learning to use the book 'Where there is no doctor'.

Part 4 covers activities with mothers and children, including children as health workers; pregnant women; mothers and young children.

Part 5 looks at health in relation to food, land and social problems.

TWO EXPLANATIONS FOR WHY IT IS BETTER THAT HEALTH WORKERS BE FROM THE COMMUNITIES WHERE THEY WORK

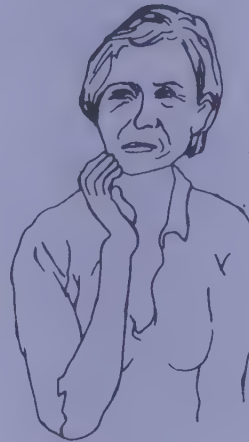
The 'expert' with little community experience:



PEOPLE ARE QUICKER TO TRUST AND LISTEN TO SOMEONE FROM THEIR OWN COMMUNITY WHO SPEAKS IN THEIR TERMS AND KNOWS THEIR CUSTOMS AND PROBLEMS.

Theory has it that community health work is *easier* for the local person than for an outsider, because people know and trust him. And he knows the community.

Persons living and working in the community:



PEOPLE ARE SLOWER TO TRUST THE NEW SKILLS OF A LOCAL PERSON. BUT WHILE AN OUTSIDER BRINGS DEPENDENCY, THE LOCAL HEALTH WORKER SHOWS PEOPLE THEY CAN DO MORE FOR THEMSELVES.

Experience shows that at first it is often *harder* for the local person. But in time, health workers from the community can do more to help build people's self-confidence and self-reliance.

Fig. 11.12.

11.2.

How can we become better teachers?

11.2.1.

What makes a good teacher? What can teachers do to help students learn?

Essilfic, N.A. (1976) Teaching practice tips.

* **Rotem, A. and Abbatt, F.R. (1982) Self-assessment for teachers of health workers: How to be a better teacher. WHO. Offset Pub. No.68.**

Chapter 1: What makes a good teacher? To improve the process of teaching it is necessary to ask: What do teachers do? How can teachers find out what they should do differently? How can they get feedback from others that will help them teach better? These are the questions tackled in this book.

The job of teaching can be divided into six major parts: planning, communicating, providing resources, counselling, assessment and continuing self-education.

Chapter 2: Planning as a part of teaching includes deciding what students should learn, how they will learn it, and how the teacher will find out whether they have learnt.

Chapter 3: Communication has to do with conveying meaning, not just talking. It includes talking, explaining, advising, asking questions and listening. Also leading or participating in discussion groups, demonstrating, using audio-visual equipment and using techniques like role play, simulation and games.

Chapter 4: Resource provision includes clinics, homes, markets and factories, people in the health services, books, posters,

films, health centre records, patient management problems, etc.
Chapter 5: Counselling happens when students with learning or personal problems seek help from teachers whom they trust. It is an important part of the overall teaching process, since students with serious personal or general problems are unlikely to be able to learn effectively.

Chapter 6: Assessment involves the design, administration and interpretation of tests. Concerns about examinations and assessments are often expressed when teachers say things like "Even though C passed quite comfortably I don't think he will be any good on the job" or "I spend my time teaching students how to work with patients, how to communicate and listen. Then they are judged by their performance in answering multiple choice questions".

Chapter 7: Knowledge about health and health care is developing continuously, with better understanding of the disease process, of methods of preventing diseases, and methods of organising health care services. These developments clearly have implications for what students should learn during their health care training, and mean that teachers should continue their own self-education.

Suharjono (1977) The role of the University of Indonesia in overcoming diarrhoeal diseases in rural health centres.

Paediatrica Indonesiana 17: pp.239-245.

How can the University and medical school become involved with rural health needs?

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Section 1.26: Appropriate and inappropriate teaching: two stories. In one story the health worker knew many anatomical details after her training but could not remember what to do to make up a rehydration drink correctly, and the sick baby died. In the other story the health workers decided, in their course, that they must teach mothers and children how to make the rehydration drink as one of their first responsibilities. "We all remember songs" they said, so they made up a song. It can be sung to 'Twinkle Twinkle Little Star' or any simple tune.

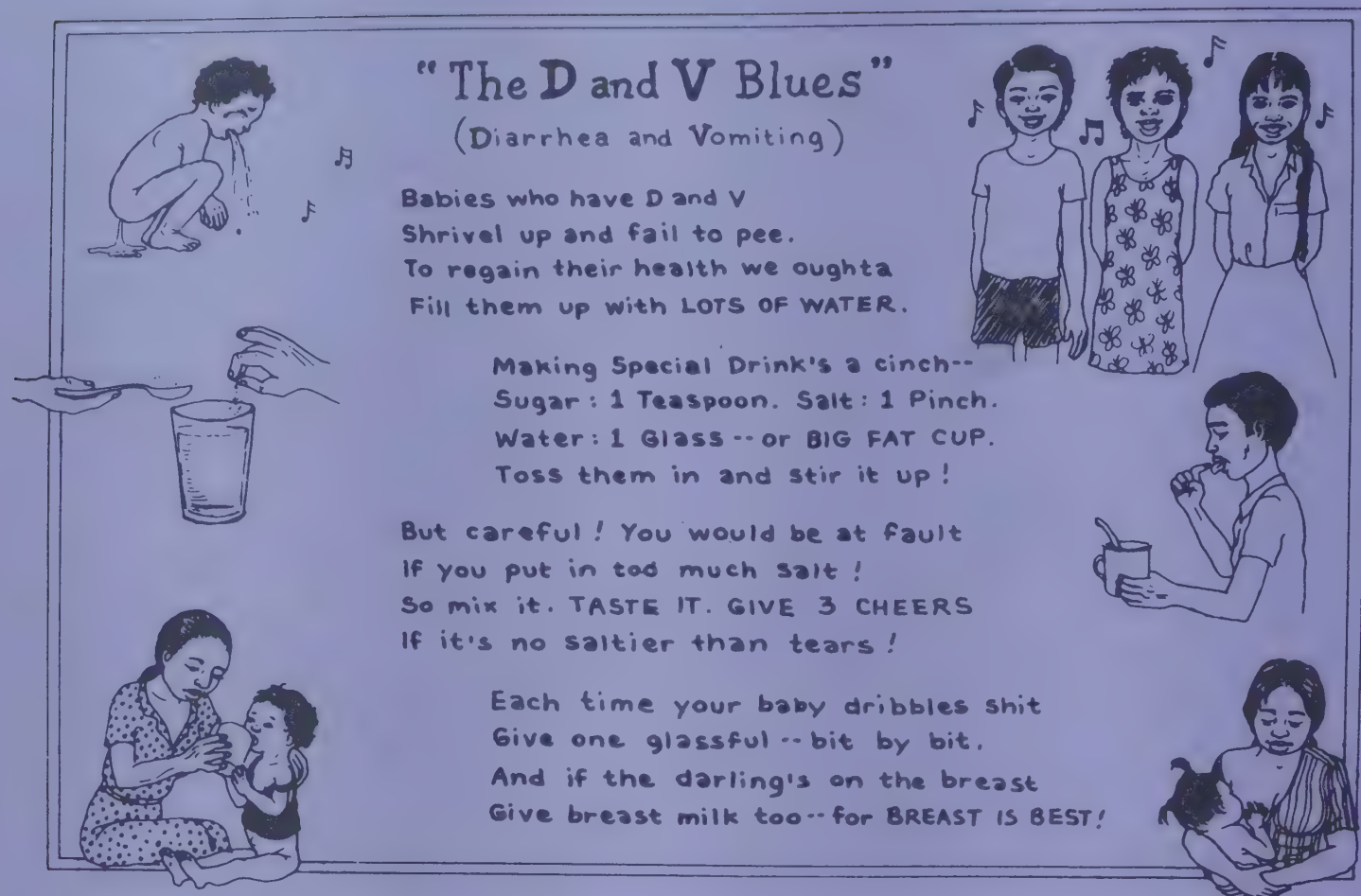


Fig. 11.13.

11.2.2.

Why are attitudes important for teaching?

* Fuglesang, A. (1982) About understanding - ideas and observations on cross-cultural communication. 231pp. Includes chapters on: The need for demystifying our words; Talking the same language and having time together; The oral civilisations - the ability to listen; We see with our experience; Community health; Pictures by people; Tenderness towards things. There are many illustrations especially of 'health education' material, with descriptions of different people's perceptions of the illustrations. Guidelines for effective pictures are also included.

Mager, R.F. (1968) Developing attitude toward learning. Attempts to explain how to recognise "approach" (enthusiasm, interest) and "avoid" (boredom, rejection, fear) responses to learning and the situations which create them for students. Chapter 2 on "Why teach" could be useful, as could the preface (2pp.) and the diagram on p.100. P.29: Three procedures to help pinpoint approach and avoidance behaviour by students are listed.

* Morley, D.C. (1973) Paediatric priorities in the developing world. Describes attitudes and their effect on work satisfaction.

Satisfaction with work

Sense of achievement

Recognition

Interest and variety

Responsibility
(long term)

Advancement

Dissatisfaction with work

Poor policy of health unit

Lack of technical supervision

Pay too low

Poor interpersonal relationship

Poor working conditions

Figure 131. Comparison of positive and negative influences in the motivation of staff

Fig. 11.14 Table from Morley, D.C. (1973) Paediatric priorities in the developing world: p.378.

* Scotney, N. (1976) Health education; a manual for medical assistants and other rural health workers.

P.50: Tablet-talking times are shown by drawings of the sun's position.

Pp.15-19: What do we do if we want to change people's habits (or think that is what ought to be done)? Practical examples and a five step process for planning health education are given.







			
			
Name: Johnny Brown			
Medicine: Piperazine 500mg. tablets			
For: Threadworm			
Dosage: take 2 tablets twice a day			

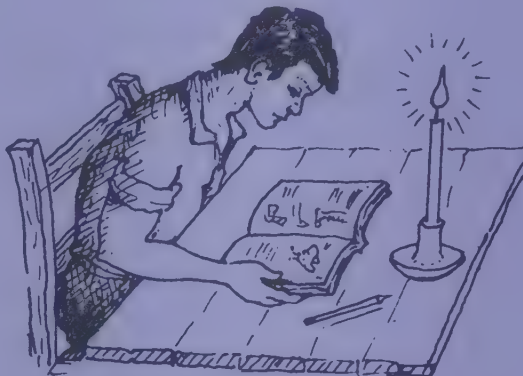
Fig. 11.15: Rural pharmacists may mark envelopes for pills for illiterate people with a variety of signs. In this way everyone can understand the instructions. Source: Werner, D. and Bower, B. (1982) Helping health workers learn.

* Werner, D. (1977) Where there is no doctor.
 Pp. W2-W7: The introduction includes some of the principles needed by village health workers (and their teachers): compassion, knowledge of the limits of their skills; the will to keep on learning; the need to practise what is taught; and the motivation to work for people not money (people are worth much more). It is accompanied by delightful illustrations.



HAVE COMPASSION.
 Kindness often helps more than medicine. Never be afraid to show you care.

Fig. 11.16.



KEEP LEARNING—Do not let anyone tell you there are things you should not learn or know.

Fig. 11.17.

6. PRACTICE WHAT YOU TEACH.

People are more likely to pay attention to what you do than what you say. As a health worker, you want to take special care in your personal life and habits, so as to set a good example for your neighbors.

Before you ask people to make latrines, be sure your own family has one.

Also, if you help organize a work group—for example, to dig a common garbage hole—be sure you work and sweat as hard as everyone else.

A good leader does not tell people what to do. He sets the example.



PRACTICE WHAT YOU TEACH
 (or who will listen to you?)

Fig. 11.18.

7. WORK FOR THE JOY OF IT.

If you want other people to take part in improving their village and caring for their health, you must enjoy such activity yourself. If not, who will want to follow your example?

Try to make community work projects fun. For example, fencing off the public water hole to keep animals away from where people take water can be hard work. But if the whole village helps do it as a 'work festival'—perhaps with refreshments and music—the job will be done quickly and can be fun. Children will work hard and enjoy it, if they can turn work into play.

You may or may not be paid for your work. But never refuse to care, or care less, for someone who is poor or cannot pay.

This way you will win your people's love and respect. These are worth far more than money.

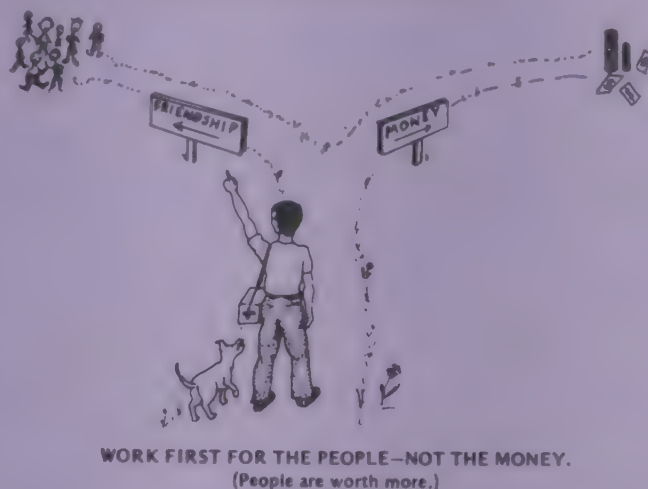


Fig. 11.19.

* **Werner, D. and Bower, B. (1982)** Helping health workers learn.

Three different approaches to education are distinguished: one sees students as passive empty containers to be filled with standard knowledge; another sees students in need of care, who need to be watched closely and spoon-fed; a third sees students as active, able to take responsible decisions when treated with respect and as equals. In the first case the teacher may well be feared; in the second case the students may feel gratitude to the teacher as a friendly parent-like authority; in the third case the students may well trust the teacher who is seen as a facilitator who helps everyone look for answers together.

* **WHO/BLAT (1985, In press)** Facilitating teaching - learning with modules. An approach for nurse midwife teachers. 2nd revised edition.

Asks the basic questions. How many teachers use many teaching methods rather than relying only on the lecture? Allow students not to attend classes? Allow students to omit courses when they already know the content? Allow students to finish early if they have mastered the material, or stay longer in the course if they need more time to master it?

11.2.3. How can learning material be developed and used in rural areas?



Fig. 11.20: VHAI (1978) Teaching village health workers, a guide to the process; a teaching pack.

11.2.3.1. Using active learning.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

Hearing, seeing or doing lead respectively to forgetting, remembering or knowing, i.e. everyone learns best by taking an active part in finding out new things.

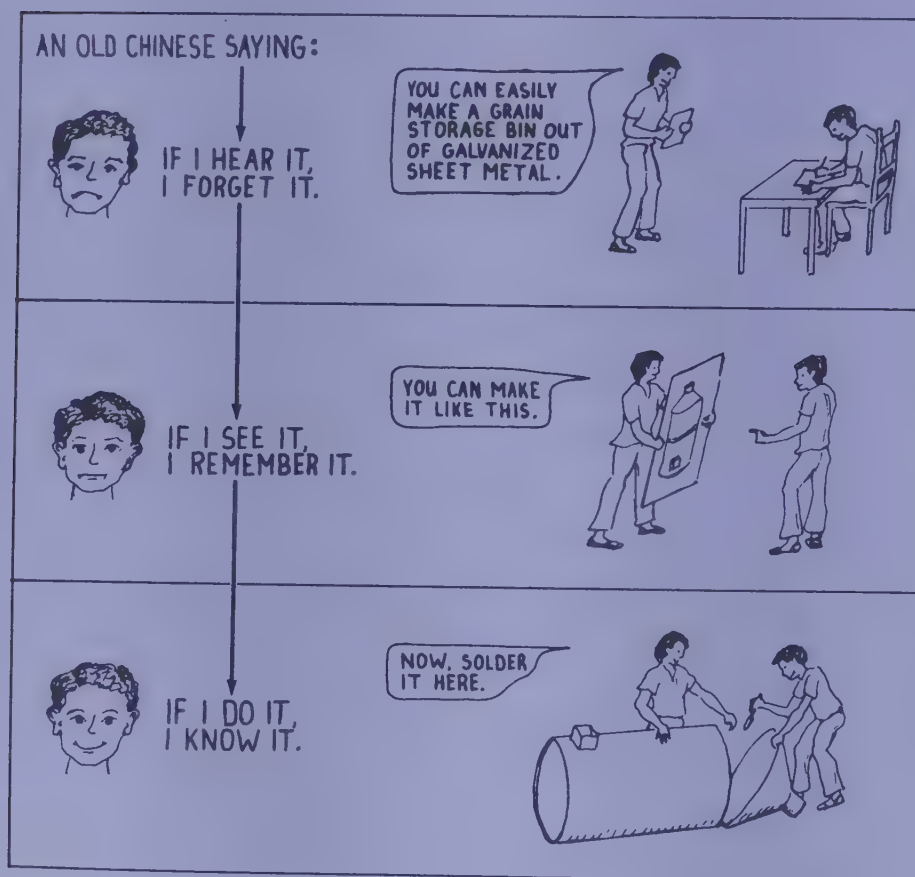


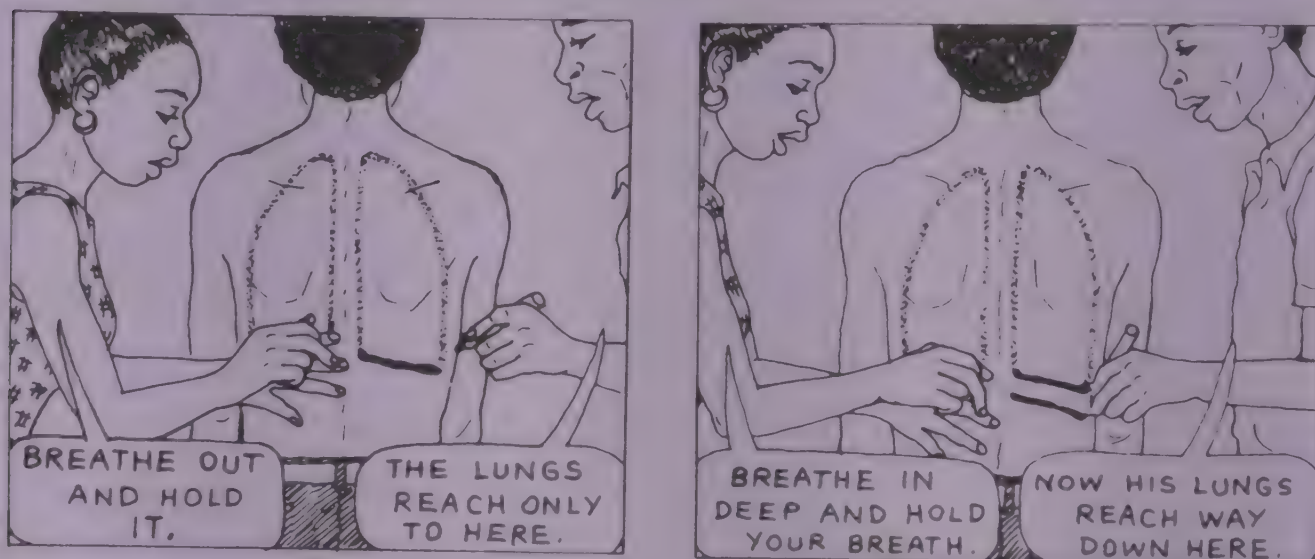
Fig. 11.21: Making and using teaching aids

6. TEACHING NEW SKILLS OR IDEAS BY COMPARING THEM WITH THINGS THAT ARE FAMILIAR

Example: Thumping (percussing) the lungs

When teaching about physical exam or respiratory problems, you probably will want to explain where the lungs are and how they work. For this, it helps to draw the lungs on a student, as shown on page 11-7. Draw them on both the chest and the back.

To determine the size of the lungs, show students how to thump or *percuss* the back, listening for the hollow sound of air in the lungs. Draw the bottom line of the lungs first when they are as empty as possible, and then when they are full. Students will see how the movement of the *diaphragm* (a muscular sheet below the lungs) affects breathing and lung size (also see p. 11-13).



By doing this, students not only learn about the position, size, and work of the lungs, they also learn a useful skill for physical examination—thumping the lungs to listen for relative hollowness. This can help them spot signs of disease.

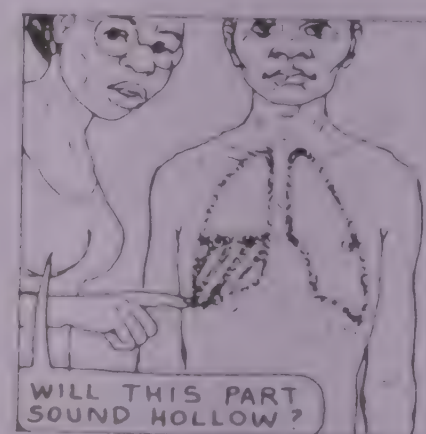
To help students understand the different sounds they hear when thumping, have them determine the level of water (or gasoline) in a large drum or barrel.



Then thump the chest of a student.



Next, compare with a person who has a solid (diseased) area or liquid in a lung.



If possible, also show the students X-rays of normal and diseased lungs.

Fig. 11.22.

• Wood, C.H., Vaughan, J.P. and de Glanville, H. (1981)
Community health.

Contrasts giving a health talk and discussing a health problem.

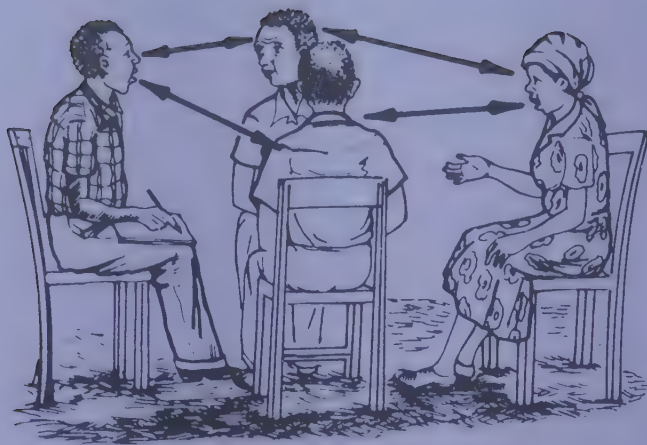


Fig. 11.23: Discussing a health problem.



Fig.11.24: Giving a health talk.

11.2.3.2.

Recognising the importance of people's facial expressions

* Werner, D. and Bower, B. (1982) Helping health workers learn.

"The importance of drawing people's expressions.

The drawings below are part of a series, produced in Guatemala for teaching mothers about nutrition. The health worker holds up a picture and asks "What do you see?" or "What is happening here?". The women look at the pictures and at once they notice the expressions on the faces of the mother and child. These expressions tell the message more clearly than words.



Fig. 11.25:

Be sure the expressions and 'body language' of pictures agree with and strengthen the message you want to communicate."

11.2.3.3.

Pictures, puppets and posters

Adams-Ray, J. and Garner, F.H. (1972) Talking pictures for patient contact. *J. Med. Soc. New Jersey* 69 (10): pp.859-867. Contains pages of pictures interpreting the sort of problems for which a patient consults a health worker. They can be used to help the health worker find out how severe the complaint is and when it occurred, etc., if there is a language problem.

* **Baird, B.** (1971) Puppets and population.

P.5: "Effective learning is most likely to take place when educational opportunity intersects with vital daily concerns". When puppets were first used in Germany, it was the habit of the old travelling puppet shows to send a man on a day ahead to learn what he could about the people in the villages where they were to play. By the time the show arrived it was topical and very personal. The puppeteers knew the names of the blacksmith and the baker. They knew the foibles of the mayor and his wife. All this was woven into the puppet show.

Why puppets? After a puppet show in one Indian village, 403 people lined up to be vaccinated when they had witnessed in the play the dangers of smallpox. Puppet shows can be put on anywhere with a minimum of equipment.

Procedures for a puppet show: preparation, performance and follow up.

Preparation - find out the history of the topic to be covered, perhaps there has been an extension programme before; find out the community resources, the influential groups, the village headman, the strong woman, the district commissioner, the health officer, etc; all these people should help determine when a play is to be given and with what emphasis.

Performance - scripts prepared as examples include: the loop (a discussion between 2 men), the condom, the contraceptive pill.

Live local music is best for setting the scene.

Follow-up - puppeteers move into the audience and start the questions as sometimes the crowd may be shy in starting talking.

* Coen, V.R. (1968) Audio-visual handbook.

Lists types of visual aids and how to use them. Aims to inform the teacher: what types of aid will be most useful for a particular purpose; how to make it; how and where to obtain it; what equipment is necessary and available; how to operate the equipment; what to do in the event of equipment failure; how to maintain the equipment. Points out that audio-visual materials and equipment are no substitute for the teacher: their effective use depends on an energetic imaginative approach by the teacher who also has a clear idea of what the learner should be helped to do.

Colle, R. and Fernandez, S. (1978) The communication factor in health and nutrition programmes; a case study for Guatemala. *Cajanus*. 11: pp.151-196.

Coppen, H. (1970) Visual perception; a review of the literature relevant to the development of teaching materials in the Commonwealth.

Currently out of print.

Coppen, H. (1963) Wall sheets; their design, production and use.

Currently out of print.

Wall sheets include friezes, photographs on mounts, charts, pictures and posters. They can be used as teaching aids or as pictures to create "atmosphere", and for reference, for introduction, or for revision. An assessment form for wall sheets can be found on p.19 of the book.

Making wall sheets: Professional and amateur production is covered. For amateur production five processes are outlined: (1) gathering and selecting information, (2) planning a layout in miniature, (3) making a rough draft, (4) charts to stimulate discussion should emphasise comparison and (5) posters to change attitudes depend on emotion for their effect and need to be strikingly simple.

Protection and storage of wall sheets: Practical suggestions (pp.34-36).

Fernau, C.N. (1979) The use of photographs in worker's education.

A handbook of how the camera works, how to cope with its lenses, films, etc.

* Kassler, R. (1977) Lettering and drawing do-it-yourself.

A small well illustrated handbook of how to help oneself in drawing; enlarging or reducing pictures; lettering; colouring; making models and mock-ups.

* **Kassler, R.** (1977) Projection arrangements and overhead projector.
Contains good illustrations.

* **McBean, G. et al.** (1980) Illustrations for development.
A manual for cross-cultural communication through illustration, developed from workshops for artists in Africa.

* **Saunders, D.J.** (1974) Visual communication handbook;
teaching and learning using simple visual materials.

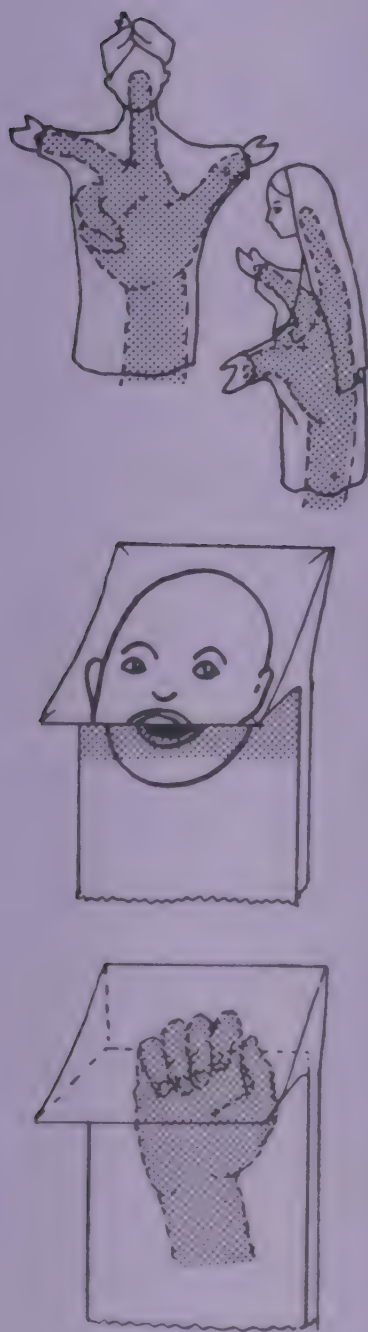


Fig. 11.26.

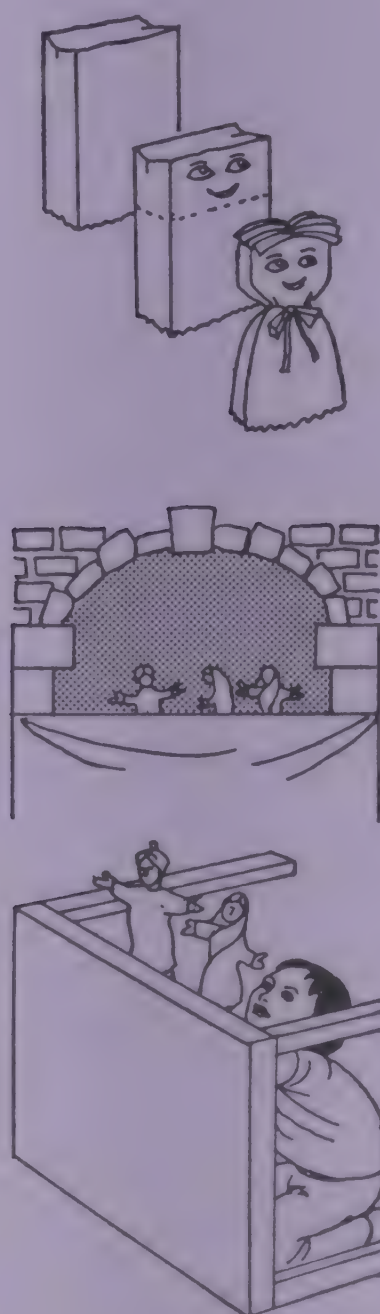


Fig. 11.27.

11.2.3.4. Using distance teaching

ACCT (Agence de Cooperation Culturelle et Technique) (regular) Teledocumentation (l'innovation technologie et ses applications). Fr.

* Hall, B.L. (1978) Mtu ni afya, Tanzania's (radio) health campaign. A report may also be available from Institute of Development Studies, University of Sussex. See also International Extension College Broadsheet No.6.

* International Extension College (quarterly series)

Broadsheets on distance learning:

- (1) Multimedia approaches to rural education.
- (2) The techniques of writing correspondence courses.
- (6) Voices for development: the Tanzanian national radio study campaign.
- (9) Editing distance teaching texts.
- (?12) Media in health education.

Further titles are probably now available.

* International Extension College (1979) Writing for distance education, Vol. I: Manual, and Vol. II: Samples.

Pan American Health Organization (PAHO) (1975) Television and crayons fight disease in Surinam. Mimeo.

PAHO 75th Anniversary Feature.

Describes how television and crayons were used for schistosomiasis teaching.

World Bank (1977) Interactive radio for health care and education in Alaska by Osvaldo Kreimer. In: Radio for education and development: Case studies, Vol. II. World Bank Staff Working Paper No.266.

11.2.3.5. Other reference material on developing learning materials

FAO (1974) Education and extension communication.

A folder containing descriptions and drawings of how villages can be helped in developing their techniques of extension work.

* Fuglesang, A. (1982) About understanding - ideas and observations on cross-cultural communication. 231pp. Explains: the problems to avoid in preparing pictures; the difference in the ways that literate and illiterate people interpret a simple line drawing, a silhouette, a blackout of a subject and a photograph; the problems experienced with posters; and the use of posters in telling a story. Also considers the principles involved in visualising material: exaggeration; linking with local oral metaphors; "human appeal".

Fuglesang, A. (1977) Communicating appropriate technology. Development Dialogue No.1: pp.64-72.

P.70: Communicating in the community: "You see I go with new business, I don't want to hurt my people, make them feel they do things wrong way". This and other quotations could be used to

develop local case studies for teaching how a community may be approached with new ideas (i.e. slowly) and what problems (like hurt feelings or shame) need to be avoided.

* **Gordon, G.** (In press) Let's make puppets.

A small illustrated booklet with practical suggestions for using local materials.

Holmes, A.C. (1963) A study of understanding of visual symbols in Kenya; line and shaded drawings. 31p.

Currently out of print although very useful.

* **Holmes, A.C.** (1968) Visual aids in nutrition education; a guide to their preparation and use.

Particularly useful for: leaflet layout; symbols; flip charts; puppets; enlargement or reduction of pictures by squares; a guide to correct proportions in figure drawing.

* **Inter-Action** (1975) Print: how you can do it yourself.

* **International Extension College** (1979) Writing for distance education, Vol.1: Manual; Vol.2: Samples.

IPPF (no date) Instructions and recommendations for conversion of mains electricity operated slide projector to work from battery powers. 5pp. Xerox.

Peace Corps (no date) Visual aids; a guide for Peace Corps volunteers. 73pp.

A small illustration bank of line drawings, mostly on hygiene, which could be easily be copied.

P.27: The usefulness of pamphlets.

P.30: Designing posters.

Pett, D.W. (no date) Audio-visual communication handbook.

Appendix 6, pp.110-112: A small illustration bank, mostly on food crops, food, domestic animals, insect parasites, vermin, tools for construction.

P.97: Gives recipes for making dyes and paints and rubber cement model material.

Pp.117-119: Notes on the use of audio-visual equipment in hot and very cold climates.

Rogers, E.M. and Solomon, D.S. (1973) Traditional midwives as family planning communicators in Asia. Case Study No.1: book, cassette script, 80 slides.

A great deal of the effectiveness of training was found to depend on the trainer: the ideal trainer needs to have credibility and competence. For traditional birth attendant training, this may sometimes be achieved by using trainers of the same age and sex as the trainees and with experience of delivering children.

* **Saunders, D.J.** (1974) Visual communication handbook; teaching and learning using simple materials.

Explains the advantages and disadvantages of many methods of teaching, and hints on how to make materials. It is particularly helpful on: selecting pictures; the advantages and disadvantages of flat pictures; drama; and puppets.

Uganda, Ministry of Health, Health Education Division (no date)
Planning visual aids and simple methods of communication.
Xerox only.

Pp.1,2: Five reasons why visual aids can help communication;
Pp.2-6: planning visual aids;
Pp.7-8: evaluating visual aids;
Pp.15-16: group discussion.

UNESCO (1957) Periodicals for new literates; editorial methods.

Producing teaching materials for semi-literates needs at least four stages: finding out what is of major interest to the audience; rewriting texts in simple language; putting in items of human interest; planning the layout using headings, sub-headings and space (the space is as important as the words, just as space is important in a courtyard or in a room).

UNESCO (1970) Preparing textbook manuscripts; a guide for authors in developing countries. 71pp.
Rather formal guidelines intended for school books. Includes a bibliography and symbols for correcting proofs.

UNESCO (1965) Rural mimeo newspapers. Reports and papers on mass communication No.46.
Part III covers how to publish regular low-cost information.

United Nations Environmental Programme (UNEP) (1976) Media pack.

This is a good example of a teaching resource pack, colour-coded to help the reader find relevant material. It is low-cost production on recycled paper.

* Wakeford, R.E. (1974) Teaching for effective learning; a short guide for teachers of health auxiliaries. 62pp.
P.25: Why are teaching aids needed? (table)
P.32: Using handouts;
P.54: Testing with "real" material;
P.35: Using an overhead projector.

Wales, L.H. (1976) A practical guide to newsletter editing and design; instructions for printing by mimeograph or offset for the inexperienced editor.

Asks the questions: Do you need teaching materials? What is your purpose, who are your audience? Explains the various procedures in editing and design; including choosing the format and materials, and provides some design hints.

* Werner, D. (1977) Where there is no doctor.
Pp. W22-W25: A useful introduction to tools for teaching.

WHO (1974) Illustration bank.

Examples of good diagrams and resource material with captions. Available in Fr. Eng. and Arabic, for teaching anatomy, menstruation, family planning techniques, presentation (lie) of foetus, environmental health.

Wright, A. (1970) Designing for visual aids.
Includes examples more geared to school work than adult education.

* Wright, P. and Barnard, P. (1975) "Just fill in this form"; a review for designers. *Applied Ergonomics*. 6 : pp.213-220.
A checklist for better form design.

11.2.3.6.

Equipment for producing low-cost teaching materials

A small offset litho machine (these are very reasonable in price).
Access to a plate cutter for the offset litho machine.
Paper and card for making flip charts.
Possibly a spirit duplicator if spare parts and spirit are available. It is best to have one which will take ordinary paper.
Material for making flannelgraphs.
A ring binder, hole maker and binder.
Plastic rings and cardboard for binding.
A slide viewer for personal use (see TALC).
An overhead projector.
A dictionary to enable recommended English material to be used.
Carbon paper.
Typewriters: with large typeface; with micro typeface for forms, diagnosis etc.
Instructions for the hand-stitching of paper material produced; this may be more practical in the long run than imported staplers which may rust and soon run out of the right sized staples.

Hecto Duplicator Company (no date) A gelatine base colour duplicator.

A 'master' in one or up to four colours is typed or written, using either Hecto carbon or Hecto pens and shading pens, on ordinary paper or directly in exercise books. It is placed on the Hecto Jelly Compound in the duplicating tray (A4 size) which has been conditioned with water. The coloured image is 'off-set' on the jelly surface. Duplicating is then a simple matter of applying sheets of copy paper to the jelly for one second contact time to make copies: up to 40 copies in five minutes. The maximum number of copies is about 100 from Hecto carbon and 50 from Hecto pens. A 'short-run' pen with blue ink will give up to 10 copies and has the advantage that the ink can be washed off the jelly surface immediately and it can be used again without delay. All other colours take an hour or more to sink below the surface before the jelly can be used again. The process is safe, simple and inexpensive.

VHAI (1978) Teaching village health workers, a guide to the process; a teaching pack.



Fig. 11.28.

11.2.4. How can teachers ensure feedback from those who are taught?

* Fuglesang, A. (1982) About understanding - ideas and observations on cross-cultural communication. 231pp.
Chapter 11: We see with our experience: includes methods of trying out illustrations.

Guilbert, J.J. (1981) Educational handbook for health personnel. WHO Offset Pub. No.35. Revised edition.
Asks: "Evaluation, what for?" Includes a checklist of defects to be avoided in evaluation, and a rationale of evaluation and the effects of testing.

Institute of Child Health, University of London (1982) MSc in Mother and child health, prospectus.

King Edward's Hospital Fund for London (1972) Assessment: a guide for the completion of progress reports on nurses in training.
A useful booklet which includes: What is assessment? Who assesses? Principles, Processes, What are the essentials of good assessment? Why is it difficult?

* Reed, F.W. (1974) Pre-testing communications; a manual for procedures. Communications media monograph No.2.

Rotem, A. and Abbatt, F. (1982) Self-assessment for teachers of health workers: How to be a better teacher. WHO Offset Pub. No.68.

A very useful booklet. Chapter 9: Evaluation instruments, outlines the uses of: a course evaluation questionnaire; a teaching skills questionnaire; student feedback on communication; clarity in a course plan questionnaire; analysing the use of questions; focusing on student behaviour; feedback on field attachments; feedback on handouts and reading material; reviewing teacher counselling; and feedback from others.

UNESCO, Kuala Lumpur (1977) Evaluating training session. Booklet 1.

Module 1 - 1 "The Benefits of Family Planning for Mother and Child"	
--- very useful	--- very informative
--- useful	--- informative
--- no opinion	--- no opinion
--- not useful	--- not informative
--- not useful at all	--- not informative at all
Comments: _____	

Table: 11.1.

One useful way of analysing the attitude evaluations is to calculate an average "informative" and "useful" ranking for each session. This average ranking can be obtained as follows: Prepare two worksheets similar to the one below. One worksheet will be for analysing "usefulness" and the other will be used for analysing "informativeness"

Participant Number	Attitude evaluation worksheet - "Useful"							
	Module	Module	Module	Module	Module	Module	Module	Total
1								
2								
3								
4								

Table: 11.2.

US, Dept. of Health and Human Services (1981) Health message testing service.

Describes a standardised approach for pretesting radio and television public service messages.

US, Dept. of Health and Human Services (1980) Pre-testing in health communications: methods, examples and resources for improving health messages and materials.

NIH Publication No.81 - 1493.

Pretesting is important in the early stages of designing new materials, for finding out what is appropriate to the target audience.

US, Dept. of Health and Human Services (1981) Readability testing in cancer communications.

Step by step instructions for performing a readability test and for improving the readability of draft materials.

* Wakeford, R.E. (1974) Teaching for effective learning; a short guide for teachers of health auxiliaries. 62pp.
Pp.49-50: Testing can give students and teachers feedback on how learning is progressing. P.48ff: "How well do you teach?"

Werner, D. (1977) Where there is no doctor.

P.W.25: "Talk with people, not at them".

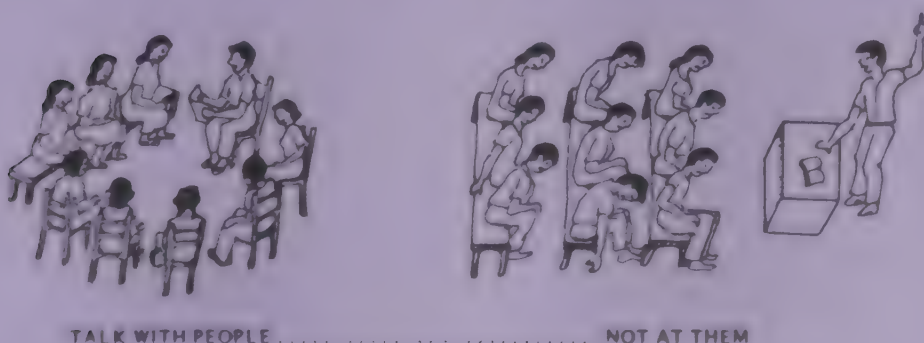


Fig. 11.29.

* World Education (1977) Evaluation; special issue. Report No.15.

Do visuals convey the meaning intended?

World Neighbors International (no date) How to test new ideas. Filmstrip. Eng. Sp.

World Neighbors International (no date) Let's try it; new ideas in agriculture. Filmstrip. Eng. Sp.

WHO (1985) Bibliography of WHO and PAHO publications dealing with health manpower development. HMD/85.2

WHO (1982) Development of instruments to assess performance of students and health personnel. HMD/82.3. 20pp.

11.3. What about the learners? How can teaching focus on specific people learning and build on local community beliefs and knowledge?

11.3.1. What encourages people to learn?

* Papua New Guinea, Dept. of Public Health (1975) Guide for teachers of aid-post orderlies and nurse aides.

Includes a role play of a woman attending a family planning clinic. Should she be prescribed the pill? For details, see Section 4.4.1. of this bibliography.

Peace Corps (no date) Visual aids; a guide for Peace Corps volunteers. 73pp.

Designed specifically for use by citizens of the USA.

P.2: Lists factors affecting motivation. These are possibly useful as a trigger for discussion, e.g. 'What encourages people to learn in your area?'

Wakeford, R.E. (1973) The law and the nurse.

A good example of how to teach a large number of facts, with amusing illustrations and in story and question and answer form. Although the book is orientated to the British legal system and the nurse working in the UK, it could be useful generally as a demonstration of how an often dry and academic subject can be made easier to assimilate.

* Wakeford, R.E. (1974) Teaching for effective learning: a short guide for teachers of health auxiliaries. 62pp.

P.50: Tests can motivate students by providing regular short-term goals and giving feed-back on how learning is progressing.

Pp.18-19: Remember what motivates your students, for example, challenges, and teaching in short steps.

11.3.2. What is a problem diagnosis approach to teaching?

See Section 11.1.3.

What problems need to be avoided (and how) in communicating with people, especially traditional birth attendants?

* Fuglesang, A. (1982) About understanding - ideas and observations on cross-cultural communication. 231pp.
Chapter 12: Community health, includes "The value of traditional medical services". There are also practical examples on how communications can go wrong; e.g. the story of the tsetse fly model which was so big that no one thought it was relevant to the "smaller" insect in their area.

* Ghana, University of Ghana Medical School (1977)
Traditional birth attendant record keeping at Danfa.
Monitors the use of stones and maize grains for recording the numbers of boys and girls born. A similar system could be used for recording numbers of stillbirths, livebirths or referrals.

Indonesia, National Workshop on Dukuns and Family Planning (1972) The role of the traditional midwife in the family planning programme; a workshop to review research.
Pp.33-36: Lists factors which may hinder Dukun training courses, e.g. problems of illiteracy, loss of income due to attendance at a course, dislike of the course; and how to overcome them e.g. by the selection of Dukuns for training.
Pp.16-24: Describes the role and status of Dukuns in the community.

Mager, R.F. (1968) Developing attitude towards learning.
Tries to explain the fact that much of what is learnt in a teaching situation is not what the teacher intends. Unpleasant surroundings and incoherent presentation may prevent the most excellent student being able to learn.

Peng, J.Y. et al (1974) Role of traditional birth attendants in family planning: proceedings of an international seminar held in Bangkok and Kuala Lumpur 19-26 July 1974. IDRC-039e.
Pp.61-74: Problems found and lessons learnt.

Rogers, E.M. and Solomon, D.S. (1973) Traditional midwives as family planning communicators in Asia. Case study No.1: book, cassette, print of script, 80 slides.
Describes why problems arose: inadequate training and ineffective supervision. Research showed that numerous short practical training sessions were best. Tea breaks, demonstrations, field trips and role playing are all useful methods to break up an all day session into shorter segments.

* UNESCO, Kuala Lumpur (1977) Family planning course.
Pp.25-29: Trouble shooting - what to do when group work is going wrong. Warning signs need to be noticed:

"During each activity the Course Organiser must look for these WARNING SIGNALS

If you see any of these warning signals, HELP SOLVE THE PROBLEM.

1. The activity is not understood:

- Confusion over the assignment:
- the group cannot start the work after they have discussed it.
- the group is doing work incorrectly.

- The activity is too difficult:
- most of the answers are incorrect.
- the group takes much too long to complete the task.

Explain the assignment again in different words to any group having a problem. Cheerfully tell them to try and not to worry too much about getting everything correct. Give helpful hints but try not to give any answer directly. Ask helpful questions which guide them to the correct answers. If the difficulty is severe: for the next activity, rearrange the assignment to make it easier, switch a strong person from a better group for a weak person from the poorer group.

2. The participation is not democratic:

- The group is divided:
- some of the members do half of the assignment and others do the other half and they do not receive the work as a total group.

- The group is dominated:
- 1 or more persons keep telling the group the answers, without asking others what they think.
- 1 or more persons hold all the materials while the others have nothing to work with.

- Members are passive:
- every group member is not active.
- some members are not paying attention to the group's work.

Give guidance to team work by saying things to the whole group like:

'Has everyone had a chance to give their ideas on that answer? Have you all taken a vote to see how everyone in your group feels? Yes, the work is coming along nicely but it seems as if some of the the group members haven't had a chance to say what they think.' Give direct encouragement to the members who are not participating by saying things like: 'You have some good ideas. Come over here and help the group out'. Give guidance to the dominating member(s) by saying things like: 'We all know this is not difficult for you. Perhaps you could encourage the others to try and explain how they feel...' 'Hmmm, you are doing well but we have to remember that every one

should have an equal say'. If the problem is severe: for the next activity, when distributing the materials, be sure that the quiet members get them and not the dominating members. Switch a strong person from another group with a weak person in the group being dominated.

3. Group spirit is poor:
- facial expressions are mostly negative.
 - people look bored or hostile.
 - people refuse to do the assignment.

This is not likely to happen if the warning signals have been noticed and remediated. If participants feel they are accepted within their group, they are most likely to enjoy the work. Work that is too easy is all right, for they will simply do it quickly and be ready for the next activity. If there is some problem, ask the groups how they feel they are doing. If the group really does not want to do the work, stop and discuss frankly what ever the problem is."

11.3.4. What learning methods are best for particular individuals

11.3.4.1. Traditional birth attendant training

See also Section 1 of this bibliography.

Colle, R.D. (1979) Communication and the TBA potential. Paper prepared for the WHO Inter regional consultation on TBAs, Mexico City 1979.

Egypt, (1982) TBA reporting form.

See pictures and description in Section 1.2.6.3. Evaluation of delivery care.

Ghana, Brong Ahafo Rural Integrated Development Project (1977) Traditional birth attendants' training: trainers' and traditional birth attendants' experiences with the training and use of the UNICEF midwifery kit, May 1976 - June 1977.

* Ghana, Danfa Project (1977) Traditional birth attendant training course manual.

See annotation in Section 1.2.6.3. of this bibliography.

Ghana, University of Ghana Medical School (1977) Traditional birth attendant record keeping at Danfa.

See annotation in Section 1.2.6.3. of this bibliography.

* India, Post Graduate Institute of Medical Education and Research, Chandigarh (1981) Better maternal and child health. An illustrated manual for dais. (traditional birth attendants). Almost entirely made up of line drawings. The yellow pages cover risky situations for the mother or baby; red pages indicate dangerous or harmful practices. There are many references to this manual in Section 1 of this bibliography, e.g. see Section 1.1.1.1. Screening of risk pregnancies. Section 1.1.5.2. Organisation of antenatal care.

Lovedee, I.M., Clarke, W.D., Mangay Maglacas, A. and Shah, K.P. (1982) A TBA trainer's kit.

See references in Section 1 of this bibliography.

Rogers, E.M. and Solomon, D.S. (1973) Traditional midwives as family planning communicators in Asia. Case study No.1. Book, cassette, print of script, 80 slides.

Traditional birth attendant trainee participation is helped by role playing, demonstrations and oral repetition. Role playing is used for teaching two to give an enema; a rubber doll is used to demonstrate how to deliver a baby. Often the trainees repeat rote style in singsong the main points they are learning. Highly visualised training works best: i.e. observation of actual deliveries and clinics, rubber baby dolls, pelvic models, actual pills, IUDs, referral cards.

Sudan (no date) Coin referral system during labour for nonliterate village midwives.

See Section 1.2.6.2. of this bibliography.

* Verderese, M. and Turnbull, L.M. (1975) The traditional birth attendant in maternal and child health and family planning; a guide to her training and utilisation. WHO Offset. Pub. No.18. See annotation in Section 1.2.6.1. of this bibliography.

VHAI (1977) Prevention of tetanus in the newborn by a sterile delivery pack.

See annotation in Section 1.2.6.1. of this bibliography.

* WHO (1979) Traditional birth attendants, an annotated bibliography on their training, utilisation and evaluation (unpublished). HMD/NUR/79.1

Also supplement I (1981) HMD/NUR/81.1

and supplement II (1982) HMD/NUR/82.1

11.3.4.2.

Teaching local people other than traditional birth attendants

* CHILD-to-child Programme (no date) Activity sheets: Ideas for involving children in health activities. Eng. Fr. Sp. Port. Arabic.

Colle, R.D. (1981) CSCS: an experimental audio cassette system for communicating with hard to reach people. 20pp. Mimeo.

Colle, R.D. (1976) Communicating with villagers. Paper prepared for planning seminar on agriculture for East-West Fort Institute, Honolulu. 16pp.

* Colle, R.D. and Colle, S.F. (1981) The communication factor in health and nutrition programmes. The authors identify an ideal site for communication, the Pila, an outdoor public laundering centre - where women spend from several minutes to several hours daily washing clothes and children - found almost everywhere, from large cities to small villages, in Guatemala. The authors feel that the Pila is already a communication centre. It could be a centre for nutrition and health education too. Discussions there can fit in with people's activities.

Colle, R.D. (1979) Some methods for communicating with rural women. Paper prepared for Educational Broadcasting International (British Council) 11pp.

* Colle, R.D. (1977) The traditional laundering place as a non formal health education setting. Convergence X (2): pp.32-40. Eng. with Fr. and Sp. summaries.

Danziger, S. (1970) Communicating with villagers, a new tool and its uses. ("Still", slide/filmstrip projector, inexpensive, durable, small and portable). International Development Review XII (4).

* Gordon, G. and Gordon, S. (1981) Using flannelgraphs to communicate ideas in nutrition and health. Part of a series of 7 flannelgraphs entitled "Nutrition and Child Health". Outlines the advantages of flannelgraphs (easily carried, reusable many times, simple and clear, the subject can be built up, the pictures can be left in view, quick to set up and use in homes or in a group, can be added to by the people using them, and easily used to encourage audience participation). Part of an excellent set of nutrition flannelgraphs produced for people in the Savannah area of West Africa.

* Hilton, D. (1980) Health teaching for West Africa. Stories, drama, songs developed in Northern Nigeria.

Mutambirwa, J.M. (no date) A proposed approach for effective health education services in Zimbabwe. Mimeo. 16pp. Explains to health workers how they can use traditional beliefs on health and disease causation etc. to support their teaching.

Nigeria, Dept. of Preventive and Social Medicine (1985) Health education in primary health care. WHO provisional publication. Will be available for global distribution, 1986.

Chapter 5.9: Health education focused on community events such as festivals, harvest, planting, religious holidays, market days or sporting events.

* Peace Corps (1978) Community health education in developing countries. Manual M-8. Chapter V: Educational methods in the community.

* St.Thomas' Community Health Council, London (?1981)
Children's (after school) Health Club. Report to the Community Health Council.

* Sri Lanka, Ministry of Information and Broadcasting (1976)
Basic communication skills for development workers. Communication Strategy Project. 24pp.
Very useful and well illustrated.

* Ten-house meetings
Small "ten-house" group meetings can be held during the daytime for discussions on childcare (only suitable for days when most people are not farming). These are used successfully in India. (No reference which tells about these meetings has been located).

* VHAI (1977) Better child care. 48pp. Many Indian languages. Eng. Ghanaian version also available.
Includes delivery care for villagers.

* Wakeford, R.E. (1974) Teaching for effective learning; a short guide for teachers of health auxiliaries. 62pp.
P.4: Who are your students?
P.5: What do your students want?
P.10: Detailing your students' tasks.

* Werner, D. (1977) Where there is no doctor.
Pp.W1-W29: Planning village services.

WHO, Eastern Mediterranean Regional Office (EMRO) (1981)
Traditional practices affecting the health of women and children, report of a seminar held in Khartoum, 1979. WHO/EMRO Tech Pub. No.2.

* Zelmer, A.C.L. (1979) Community media handbook. 2nd edition.

11.3.4.3. Helping health and field workers to communicate with the community in a mass campaign

AHEA (American Home Economics Association) (1977) Working with villagers. Trainer's manual, prototype lessons, media resource book.

* India, Christian Medical Association (1974) How to scientifically prepare our flashcard sets; health education begins with local beliefs. Mimeo. 2pp.

* ILO (1979) Getting together; a workers' evaluation visual aid kit for use among Asian rural workers.

* ILO, Workers' Education Programme (1979) A workers' education kit for an induction course for field representatives of rural workers' organisations in Asia. Also a flipchart. Eng. Sp. in preparation.

* World Assembly of Youth (1971) Role of communications on the local level.

Covers tasks for the communicator: how to attract the attention of an audience, pre-campaign work, the day of the meeting, methods of presentation of material at a meeting, follow-up.

11.3.4.4.

Teaching health centre health workers

PAHO (1981, In preparation) Guide for the education content of continuing education programmes in maternal and child health and primary health care for health services personnel at the first level of care. Prepared by J. Jaeger-Burns. 9pp.

* Papua New Guinea, Dept. of Public Health (1975) Family planning for aid-post orderlies and nurse aides. 35pp. Includes role play teaching, e.g. Appendix E: Mrs Buang takes the pill:

"APO Gemo: Good morning, Mrs. Buang How are you?

Mrs. Buang: Good morning, Mr Gemo. I am very well thank you, and my baby is happy and growing strong. He is a big fellow for 6 months, isn't he? I have been giving him a little of many kinds of food mashed to make them soft like you told me, as well as my breastmilk.
Mr. Gemo, my husband has come with me today because you were talking to me about family planning.

Mr. Buang: Yes, I don't want my wife to have another baby for 2 more years. Then James can have breastmilk for a long time and Mary can be quite strong again. We read this book which you gave to Mary and we decided that she should take pills to space our children.

APO: Yes, that is a good method. While she takes a pill every day she will not get pregnant. When she stops taking the pills she can have another baby I will check your wife to make sure it is all right for her to take the pills.
First I will ask you some questions. (The APO asks her the question on the checklist and marks the paper to show whether she answers "yes" or "no").
Now I will make sure that everything is all right. (The APO examines her to make sure she is well, and marks the checklist).
Yes, everything is all right for you to take pills. Have you started to have monthly bleeding again since baby was born?

Mrs. Buang: No, not yet.

APO: Very well, then you can start taking the pills tonight.

Mrs. Buang: Why did you ask me that? What would I do if I had started to have monthly bleeding again?

APO: If a woman is having monthly bleeding she must start the first packet of pills on the first day of her next bleeding.

Mrs. Buang: Will you explain to my husband too? He will help me to take them the right way.

APO: The best time to take the pills is after your food at night. You always start with the pill under the red spot. You will take this pill tonight. Tomorrow night you will take this pill. The next night you will take this pill. You follow the arrows and take one pill every night until the packet is finished.

Mr. Buang: Mr. Gemo, how do you get the pills out of the packet?

APO: You will see on the other side of the packet that all the pills are in plastic bubbles. Press the bubble with your finger and this will push the pill up, and break the silver paper. Then you can take out the pill. You see that the pills are not all the same. Some are a different colour. That is why it is very important that the pills are all taken in the right order.

* **Saunders, D.J.** (1974) Visual communication handbook; teaching and learning using simple visual materials.

* **Sri Lanka, Ministry of Information and Broadcasting** (1976) Basic communication skills for development workers. Communication Strategy Project.

* **Vella, J.K.** (1979) Visual aids for non formal education: a field guide.

* **Wakeford, R.E.** (1974) Teaching for effective learning; a short guide for teachers of health auxiliaries. 62pp. See annotation in Section 11.3.4.3. of this bibliography.

* **WHO** (1981) Health education methods and materials in primary health care. Appropriate Technology for Health Newsletter. No.10.

* **Zaire, Bureau d'Etudes et de recherches pour la promotion de la sante** (1980) L'education de la sante. Brochure of relevant material available (26 documents). Fr.

11.3.4.5.

Teaching district level health workers

See also Section 5 on immunisation.

* Church, M. and Cronin, A. (1979) Health education jargon generator.

Drummond, T. (1975) Using the method of Paulo Freire in nutrition education: an experimental plan for community action in Northeast Brazil. Cornell International Monograph Series No.3.

Guilbert, J.J. (1981) Educational handbook for health personnel. WHO Offset Pub. No.35.

* Harnar, R., Zelmer, A.C.L. and Zelmer, A.E. (1983) A manual of learning exercises for use in health training programmes in India.

* Hopwood, B.E.C. and Lovel, H.J. (1976) The Wallo exercise, planning rural health services in Africa, a game.

* ILO Beginner workers' education series.

* (1) (1977) The teacher's tools.

* (2) (1977) Simple reproduction techniques.

* (3) (no date) How to produce a slide show (filmstrip).

* (4) (no date) The use of sound in workers' education.

* (5) (no date) Selected methods in workers' education.

* (6) (no date) Methods and techniques of workers' education (filmstrip).

* (7) (no date) The work-life connection.

* IPPF (no date) Instructions and recommendations for conversion of mains electricity operated slide projector to work from battery power. 5pp. Xerox.

* Lesotho, National teacher training course (?1981) Self instructional material for: (1) Bar graphs (2) Relations in mathematics.

* Siddall, S. and Platts, C. (1982) Getting the message across, a step by step guide to making health service notice boards and displays interesting and effective.

Sierre Leone, Dept. of Health Education (regularly) Newsletter.

* Sri Lanka, Ministry of Information and Broadcasting (1976) Basic communication skills for development workers. Communication strategy project.

* Werner, D. and Bower, B. (1982) Helping health workers learn.

WHO, Eastern Mediterranean Regional Office (1978) Health education with special reference to the primary health care approach. Int. J. Health Ed. XXI (2) Supplement. 19pp.

* Zeitlyn, J. (1982) Low cost printing for development. Short, clearly printed guides with illustrations. Booklet 1: Introduction and design; Booklet 2: Do it yourself methods; Booklet 3: Using a printer; Booklet 4: Setting up your own printshop.

* Zelmer, A.C.L. (1982) Preparing simplified learning materials.

11.3.4.6. Teaching national level health workers

* Ryle, A. (1969) Student casualties.
Examination of the causes of emotional ill health amongst university students.

Volunteers in Asia Inc. (1982) Microfiche appropriate technology reference libraries at 1/20 the cost of paper collections.

11.3.4.7. Teaching in schools and to the general public

Many new courses for schools are being developed. Contact publishers e.g. Longman, for current material.

UNESCO (1980) Evaluation of the content of general education over the next two decades. ED-80/CONF.803/COL.22.

Wosornu, L. (1977) Aspects of health education for everyone. Mostly focused on diseases including: malaria, yellow fever, typhus, typhoid fever, amoebic dysentery, cholera, whooping cough, tuberculosis, leprosy, infective hepatitis, measles, etc. There is a useful chapter on the abuse of antibiotics and also sections on some common chronic diseases, common cancers, growth and development, especially adolescence and growing old.

11.4. What about the topic being taught? What teaching methods best suit particular subjects?

See each subject Section of this bibliography.

See also Section 11.5. Keeping up to date with teaching methods.

* Mears, R.K. (no date) Some thoughts on curriculum development.

Certain elements or characteristics of health need to be taken into account in designing curricula:

- 1) health is a multi-dimensional unity of man;
- 2) health depends upon multiple factors;
- 3) health is a state of being, a way of behaviour, or a quality of life;
- 4) health has different meanings for different people;
- 5) health is a dynamic process, not a static condition;
- 6) health is not a goal in itself but is implicated in attaining specific goals;
- 7) health is determined not by what we know but what we do;
- 8) health is seldom perfect - there are almost always ways to improve one's health.



Fig. 11.30: "The triad symbol of the School Health Education (i.e. Study) captures something of the current concept of health in relationship to the teaching-learning process. One facet of the triad represents health, in terms of its physical, mental, and social dimensions. Another relates to behaviour including knowledge (cognitive domain), attitudes (effective), and practices (action or psychomotor). A third part of the symbol provides the focus, including the individual, family, and community. All of the components are interdependent and result in dynamic interaction."

Zelmer, A.E. and Zelmer, A.C.L. (1976) Pros and cons of experimental learning through simulations in health education Mimeo. 10pp.

Zelmer, A.E. and Zelmer, A.C.L. (1976) Simulations and games in nursing education. Mimeo. 28pp.

11.5. Keeping up to date with teaching methods

The following publications include practical information on how to teach, and addresses of suppliers of low-cost health training material.

* **Adult Education and Development** (monthly) Newsletter. Dept. for Education in Developing Countries, 5300 Bonn-Bad, Godesberg, Heerstrasse 100, Federal Republic of Germany. Eng. Fr. Sp.

Commonwealth Secretariat (?1980) The case study as a training method, a select bibliography. Marlborough House, Pall Mall, London, W1Y 5HX, UK.

Devitt, M. (1970) Learning with 'Jackdaws'. Jackdaws Publications, 30 Bedford Square, London, WC1, UK. 'Jackdaws' are teaching packs containing facsimile documents of maps, posters, charts, etc. and broadsheets giving background material on a subject. Each 'Jackdaw' measures $13\frac{1}{2} \times 9$ ".

* **Development Communication Report** (monthly) Regular "Communications Checklist". Newsletter. Clearinghouse on

Development Communication. 1414 22nd Street NW, Washington DC 20037, USA.

Information (6 times a year) BLAT Centre for Health and Medical Education BMA House, Tavistock Square, London WC1H 9JP, UK.
Annual subscription [10.00 approx.

* **The Learner** (quarterly) WHO, Eastern Mediterranean Regional Office (EMRO) PO Box 1517, Alexandria, Egypt.

* **Medical Education Newsletter** (irregular) Centre for Medical Education, University of Dundee, Scotland, UK.

* **NFE Exchange** (monthly) Newsletter. Institute for International Studies in Education, Michigan State University, USA.

* **Salubritas** (monthly) Free newsletter on innovations in teaching health topics. APHA, 1015 Fifteenth St NW, Washington DC 20005, USA.

* **Teaching Aids at Low Cost (TALC)** (annual) Newsletter. PO Box 49, St. Albans, Herts, UK.

11.6. Keeping up to date with new ideas in community health

11.6.1. Newsletter and sources of material on community health

Health
workers
need and
love
books



but
hate
today's
prices

Fig. 11.31.

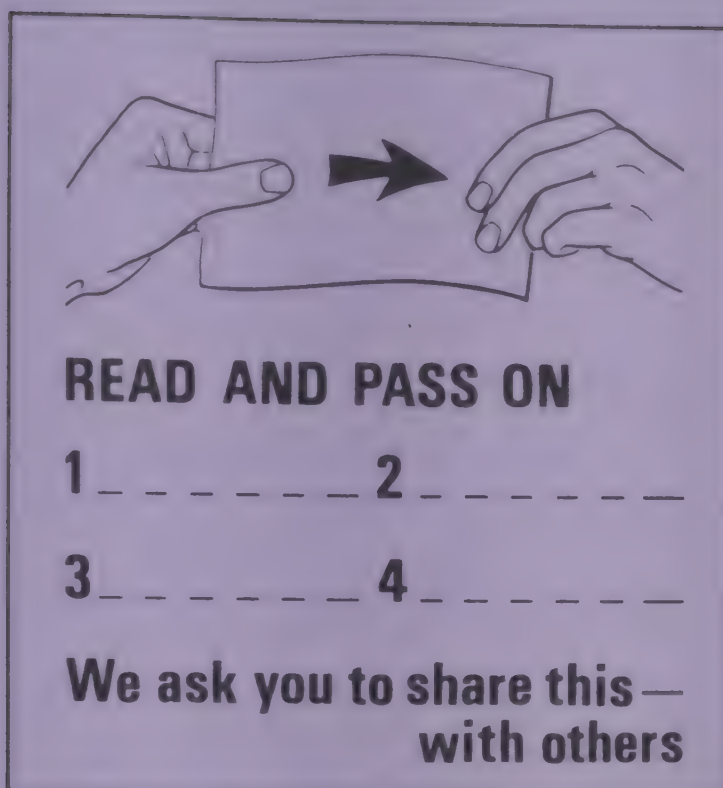


Fig. 11.32.

Source of illustrations TCHU. These illustrations may be reproduced.

For nutrition newsletters, see Section 2.5.

For family planning newsletters, see Section 4.6.

For water and sanitation newsletters, see Section 6.1.1.4.

For teaching methods newsletters, see Section 11.5.

* **AMREF** (occasional) List of publications. Health Education Dept. PO Box 30125, Nairobi, Kenya.

* **AMREF** Newsletter. Health Education Dept. , PO Box 30125, Nairobi, Kenya.

ACCT (Agence de cooperation culturelle et technique) Direct: les echanges de programmes audio visuels. Bulletin mensuel sur l'utilisation de la technologie en education public par le Centre d'information et d'echanges-television de l'Agence de cooperation culturelle technique, 19 Avenue de Messine, 75008 Paris, France.

APHA (American Public Health Association) Mothers and Children. Eng. Fr. Sp. Free to health workers in developing countries. Includes information on programme activities in MCH programmes worldwide; new developments in legislation; maternity issues; new resources and trainee opportunities.

* **APHA** (American Public Health Association) (monthly) Salubritas. 1015 Fifteenth Street NW, Washington DC 20036, USA. A health information exchange.

* **AHRTAG** Information leaflet. Appropriate Health Resources and Technologies Action Group Ltd., 85 Marylebone High Street, London W1M 3DE, UK.

Appropriate Technology and Missions Newsletter, c/o Stephen Ranney, (ed.), 35 NE 32 No.2 Portland, OR 97232, USA.

This bulletin provides information on small-scale technology, new books, training, and other aspects of appropriate technology. One issue carried: detailed instructions for making soap; information on refrigeration that does not require electricity; and book reviews. Subscriptions cost \$2.95; a free sample copy is available on request.

* **Asian Community Health Action Network (ACHAN)** (?quarterly) Link Newsletter. ACHAN, Flat 2A, 144 Prince Edward Road, Kowloon Hong Kong.

* **Brazil, Teaching Aids at Low Cost Portuguese (TAPS)** Ms. Hildegard Bromberg-Richter, Caixa Postale 20833 01000 Sao Paulo, SP State, Brazil.

Teaching materials which would be useful for all Portuguese speaking countries, e.g. Angola, Mozambique, Guinea-Bissau etc. They have included translations of Contact, Where there is no doctor, and Paediatric priorities in the developing world. Other items have included a Portuguese oral rehydration mix spoon and a series of community health booklets.

* **Cameroon** (sources of information): Compagnie camerounaise de developpement regional, (C.C.D.R.), B.P. 4144, Yaounde, Nlong, Kak, Cameroon.
INADES, Douala, Cameroon.
IPD, Douala, Cameroon.

* **Centre for World Development Education** (?quarterly) Catalogue of resource materials for sale.
Mostly aimed at development education for children in developed countries.

* **CHILD-to-child** (occasional) Newsletter. CHILD-to-child Programme, c/o Institute of Child Health, 30 Guilford Street, London WC1N 1EH, UK.
Eng. Fr. Sp. Port. Arabic.

Children: Development Trends in Pakistan UNICEF, P.O. Box 1063, Islamabad, Pakistan.

This magazine is dedicated to the children of Pakistan and is a forum to highlight children's needs. Eng.

* **Christian Medical Commission** (monthly) Contact. World Council of Churches, 150 Route de Ferney, 1211 Geneva 20, Switzerland.
Includes illustrated descriptions of innovative health programmes.

Colle, R. (occasional) Useful information on learning where people are busy. (e.g. while washing clothes at the well). Dept. of Communication Arts, New York State College of Agriculture and Life Sciences, Cornell University, 640 Stewart Avenue, Ithaca, New York 14850, USA.

* **Community Education Supplement** (?quarterly) Community newspaper produced by the Open University, Milton Keynes, UK.
Good example of something useful for many areas.

* **Development Communication Report** (monthly) Clearinghouse on Development Communication. 1414 22nd St. NW, Washington DC 20037, USA.

* **East-West Centre** (?quarterly) IEC Newsletter. 1777 East West Road, Honolulu, HI 96848, Hawaii.

* **Echo** (regular) Basic equipment lists for rural health centre and village clinic. Joint Mission Hospital Equipment Board Ltd., 4 West Street, Ewell, Surrey KT17 1UL, UK.

* **El Informador Comunitario** (?monthly) Asociacion de Servicios Comunitarios de Salud (ASECSA) y Comité Regional de Promocion de Salud Comunitaria, Apartado Postal No.27, ciudad de Chimaltenango, Guatemala.

Folmer, H.F. and Peter, W. (no date) MEDDIA international slidebank and booklets on tropical diseases. Royal Tropical Institute, 1092 AD Amsterdam, Netherlands.

Front Line Doctor (?quarterly) News sheet of the Faculty of General Medical Practice, National Postgraduate Medical College, Nigeria.

Future (quarterly) UNICEF House, 73 Lodi Estate, New Delhi 110003, India.

Children and development in South Central Asia and other countries are the subjects of this 64pp magazine put out by the UNICEF Regional Office for South Central Asia. The first issue (fourth quarter, 1981) featured: schools for children who live on the Calcutta pavements; children at work; disabled young people; and nutrition.

Ghana, Ministry of Health (occasional) Health Magazine. Health in Ghana Series No.7. Health Education Division, Ministry of Health, Ghana.

One issue of the series includes discussions on the doctor-patient relationship, mental health in schools, nutritional problems in Ghana, drugs use and abuse etc. It is intended as a forum for discussion amongst senior health workers.

* **Graves Medical Audiovisual Library Newsletter** (quarterly) Holly House, 220 New London Road, Chelmsford, Essex CM2 9BJ, UK. A very useful source of tape-slide material, covering many aspects of health care and medicine for many types of health worker. 20-25 new titles are announced with each newsletter.

HAI News The Editor, HAI News, IOCU, Regional Office for Asia and the Pacific, PO Box 1045, Penang, Malaysia.

"HAI" stands for Health Action International, an informal network of consumer, professional, development action, and other public interest groups working on pharmaceutical issues. Circulation is limited to participants in the HAI network. The first issues of HAI News (October and December 1981) carried: information on the network; news of local production of generic drugs; and other actions, congresses, meetings, and publications concerning drugs and the drug industry.

Hygie, International Journal of Health Education (quarterly) Eng. Fr. Sp. IUHE, 9 Rue Newton, 75116, Paris, France. Each issue of this journal of health education carries: a report on field activities; a dossier (the first issue concentrates on childhood health problems); and news briefs on the activities of the International Union for Health Education (IUHE).

* **India, Centre for Development Communication** (occasional) Useful publications list. Centre for Development Communication, 23 "Jabbar Buildings", Begum pet, Hyderabad 500 016, India. Includes flash cards, filmstrips, slide sets, photos, language songs, etc.

* **Indonesia, Vibro** Newsletter on health topics. Yayasan Indonesia, Sejahtera, Central Java Republic, Jalan Kenanga 163, Solo, Indonesia.

* **Institute of Child Health, University of London** (1982) MSc in Maternal and Child Health prospectus. 30 Guilford Street, London, WC1N 1EH, UK.

Illustrates what happens to the doctor (or nurse) who does not continually further his/her education; (the original training is soon forgotten and left behind, much of it soon becomes out of date as well; all health workers need to keep up with new ideas and developments).

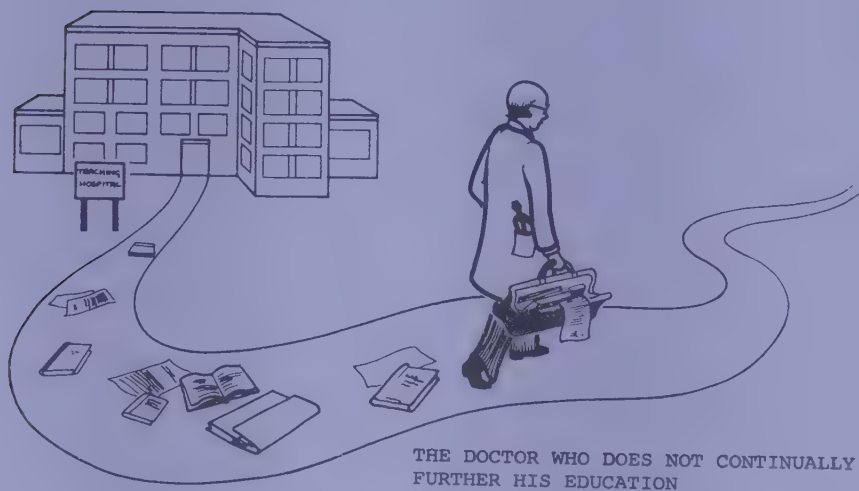


Fig. 11.33. "While specialist training is often readily available, programmes are only just beginning for the on-going training of the district medical officer and other members of the district health team".

* **International Children's Centre, Centre International de l'Enfance.** Information leaflets, publications list, technical reviews list. Chateau de Longchamp, Bois de Boulogne, 75016 Paris, France. Eng. Fr. Sp.

International Christian Relief (?quarterly) ICR News. PO Box No.1, Kings House, Bedworth, Nuneaton, Warwickshire CV12 8LG, UK.

* **International Labour Organisation, ILO** (annual) Publications list.

* **International Women's Tribune Centre** (quarterly) Newsletter. IWTC, 305 East 46th Street, New York, NY 10017, USA.

The newsletter (on average 20-30pp. covers all aspects of women and development issues including: appropriate technology for women; women and media; women and food.

Journal of Family Health Training (quarterly) International Training in Health. (INTRAH), 208 North Carolina Street, Chapel Hill, NC 27514, USA.

Carries reports from Africa and the Middle East on primary health care, family planning, and continuing education. It is published in Eng. and Fr. by the new Nairobi field office of the program for International Training in Health (INTRAH) of the University of North Carolina.

* **Kenya, Afya** (bimonthly) Community health newsletter for auxiliaries. The Editor, P.O. Box 30125, Nairobi, Kenya.

* **League of Red Cross Societies** (?monthly) Newsletter. Youth Bureau, League of Red Cross Societies, PO Box 276, 1211 Geneva 19, Switzerland.

Fr. Eng. Sp.

* **Liberia, Bong County Community Health** Newsletter. Community Health Department, PO Box 1046, Thebe Hospital, Monrovia, Liberia.

* **Liberia, Health Habit Newsletter** Curran Lutheran Hospital, Box 1048, Monrovia, Liberia.

Malawi, Ministry of Health (bimonthly) Moyo; Newsletter on health topics. PO Box 3, Blantyre, Malawi.

Medical Bulletin (?monthly) Baptist Doctors' Missionary Fellowship, Baptist Missionary Society, 93 Gloucester Place, London W1H 4AA, UK.

* **Medical Education Newsletter** (irregular) Centre for Medical Education, University of Dundee, Scotland, UK.

Mexico (organisations involved in rural development):

International Maize Improvement Centre, Apartado Postal 6-641, Mexico.

Instituto Mexicano del Desarrollo, M. Escobedo 510, 7 piso, Mexico.

Programa solar Tonatiuh, Secretaria de Salubridad y Asistencia, Sub-secretaria de Mejoramiento del Ambiente, 284 Ave.

Achaputteque, Mexico D.F., Mexico.

Editorial Pax-Mexico (booklist), 1434 Ave. Cuauhtemoc, Mexico 13, D.F. Col. Navarte.

Network IFID (quarterly) c/o IDL Rural Development Trust, PO Bag No.1. Sanatnagar (IE) PO. Hyderabad 500 018, India.

Information for International Development (IFID) is a non-profit organisation that helps answer the questions that other small organisations may have on, for example: cooperatives, domestic rabbit keeping, and sources of vegetable oil. Some of these questions and answers are published in Network IFID, the group's quarterly bulletin (No.1, June 1982).

Non-Formal Education Information Center, Michigan State University. Rural development network bulletin. The NFE Exchange Overseas Liaison Committee, American Council of Education, 513 Erikson Hall, East Lansing, Mich. 48824, USA.

* **Primary Health Care Link** (monthly) Sr. Pauline Dean, 11 Meads Road, Eastbourne, Sussex BN20 7DU, UK.

* **Rural Communications** (quarterly) Basics. 17 St. James's Street, South Petherton, Somerset, UK.
A source of shared information on: village development; appropriate technology for health and agriculture; and marketing ideas for handicrafts.

South Africa, Environmental and Development Agency (EDA)
(?monthly) Link, bulletin of the EDA. PO Box 62054, Marshalltown 2107, South Africa.

"EDA is a small independent agency which promotes community development mainly in the rural areas of Southern Africa".
Articles in 1981 included storing and preserving food and how to build a creche. Also "Doomkop farm - now an army camp" and "We don't want to move" - about compulsory resettlement.

* **Teaching Aids at Low Cost, TALC.** Communication of Innovations: A free list of useful newsletters, many of them free. Also TALC newsletter and list of books, slides and other teaching materials e.g. flannelgraphs and weight charts. PO Box 49, St. Albans, Herts, UK.

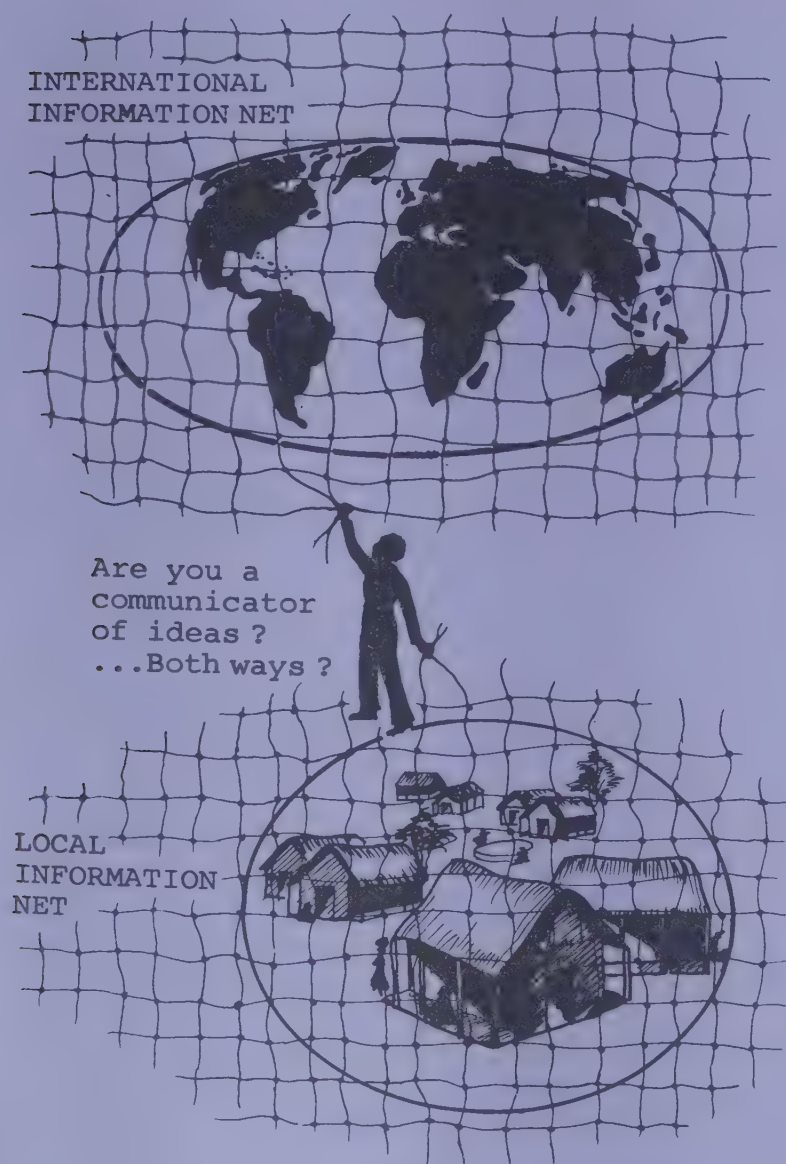


Fig. 11.34.

* **Third World Publications** (regular) Catalogue. 151 Stratford Road, Birmingham B11 1RD, UK.

Transkei, Dept. of Health (quarterly) Health Magazine, news and views from the Department of Health. The Editor, Health Magazine, Private Bag X5005, Umtata, Transkei.

Two-Way Radio Communication in Rural Health Services Development Technologies Ltd., 4337 Felton Place, Madison, WI 53705, USA.
What are the advantages and disadvantages of using two-way radios in rural health services? What technology is best for what situation? How much does it cost to set up a system? Who's who in the field? These are some of the questions that will be answered in this free English-language newsletter.

* **UNESCO** (monthly) Features. UNESCO, Paris, France.

UNESCO (annual) Publications catalogue. UNESCO, Paris, France.
Also: Periodicals catalogue (annual). Eng. Fr. Sp.

* **USAID** (quarterly) Aid Resources Report. Room 509, SA-14, Office of Development Information and Utilization, Bureau for Science and Technology, USAID, Washington DC 20523, USA.
Each issue of this quarterly newsletter reviews several books on development. Subscribers may obtain some or all of the books free of charge from the United States Agency of International Development (USAID). The November/December 1981 issue, for example, reviewed "Animal traction, a practical guide to the selection, care, and training of draft animals"; "Paraprofessionals in rural development, a study of the use of agriculture, health and community development auxiliaries", and "The appropriate technology source book, a compendium of the latest techniques in agriculture, water supply, health, and other subjects".
Libraries, ministries, governmental and non-governmental agencies may request a free subscription.

* **VHAI** (annual) Catalogue of low-cost educational materials. C-14 Safdarjang Development Area, New Delhi 1100016, India

* **World Bank** (monthly) Development Forum (16 pp. newspaper). DESI/DPI Palais des Nations, CH 1211 Geneva 10, Switzerland. Eng, Fr. Sp.
"The only regular UN publication on economic and social development".

World Bank (annual) Publications catalogue. World Bank, New York, USA.

World Education Reports series. Attn. Mr. A. Narayan, PO Box 5066, Kendall Park, New Jersey, NJ 08824, USA.

* **WHO** (occasional) Appropriate Technology for Health Newsletter, WHO, 1211 Geneva 27, Switzerland. Eng. Fr. Sp. Arabic.

* **WHO** (annual) Film catalogue. WHO, 1211 Geneva 27, Switzerland.

- * WHO/FHE (occasional) Family health - selected list of publications. FHE/83.3. WHO, 1211 Geneva 27, Switzerland.
- * World Neighbors International In action, a newsletter for project personnel. 5116 North Portland Avenue, Oklahoma City, Oklahoma 73112, USA.
- * World Neighbors International Soundings. Newsletter. 5166 North Portland Avenue, Oklahoma City, Oklahoma 73112, USA.
- * Zaire, Bureau d'etudes et de recherches pour la promotion de la sante (annual) Catalogue. B.P. 1977, Kangu-Mayombe, Republic of Zaire. Eng. Fr.

11.6.2. Occasional bibliographies on community health

AMREF/Commonwealth Regional Health Secretariat (1976) Books for health workers in the English speaking countries of East, Central and Southern Africa. 47pp.
Includes a book assessment form:

"BOOK ASSESSMENT FORM

Title	Author
Publisher	Price
For use of	

Content

Is the subject matter relevant:	mainly	partly	not at all
Is the coverage complete and well balanced:	yes	fair	no
Does it contain real examples of local application:	many	a few	none
Is the approach 'problem solving':	mainly	seldom	no
Is the level of difficulty appropriate:	yes	fair	no
Does it contain practical instructions on 'how to do it':	frequently	seldom	not at all
Is the material interesting:	yes	fair	no
Other comments:			
.....			

Presentation

Is it well laid out and easy to read (headings, type size etc):	yes	fair	no
How is it arranged:	one topic	short	long
How is it illustrated - Frequency:	per page	chapters	chapters
- Type:	many	few	none
- Colour:	photographs	diagrams	drawings
	colour	black & white	
Language - Vocabulary:	simple	moderate	advanced
- Structure:	plain	long	conditional
		sentences	clauses

Are any of the following learning aids used:
summaries, lists, abstracts, questions, tables, practical exercises, boxed slogans, other.
Other comments:
....."

AHRTAG (no date) Primary health care in developing countries - A directory of resources.

This is a list of voluntary organisations, institutions, schools, charity organisations, etc. involved in health care in the third world. It includes the names of the agencies, the countries where they are involved, and their types of work interest.

Capparelli, E.W. (1978) Delivery of primary health care for rural areas: an annotated bibliography.

Commonwealth Secretariat (1979) Health training. A directory of Commonwealth resources.

A directory of teaching institutions and resources in about 50 Commonwealth countries, with brief descriptions of the courses and type of health personnel trained in each country.

* Elliot, K. (ed.) (1979) Auxiliaries in primary health care: an annotated bibliography.

About 357 booklets, manuals and teaching materials, from several countries of the world, mainly the developing countries, are annotated. The teaching materials deal with various aspects of health care, from midwifery to leprosy management. A useful list of addresses of institutes from which the annotated material may be obtained is given. Addresses of journals and publishers mentioned in the book are also provided in the appendices.

* India, Viksat, Gujarat (1982) The great village catalogue, India.

A "catalogue of rural technologies, traditional practices and new experiments in India".

* International Children's Centre (Centre International de l'Enfance) (1981)

Publications of the International Children's Centre, May 1981; A bibliography of books, articles since 1950.

* IDRC (1975-1982+) SALUS: Low cost rural health care and health manpower training, an annotated bibliography with special emphasis on developing countries. IDRC-069e. Vols 1-7. Abstract in Eng., Fr., Sp.

Annotated bibliographies on rural health care produced by the International Development Research Centre. The coverage of these volumes includes: planning, financing, organisation, utilisation and evaluation systems in health care; the impact of health care services on social and economic indices, including demography; the relationships between health care systems and community organisations; the staffing of health care systems; the functions of different health workers especially paramedical workers, their training, distribution and utilisation; primary health care - implementation; primary health manpower - training and utilisation; and formal evaluative studies.

* ILO (1980) List of workers' education publications in English.

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* **WHO** Publication catalogue 1947-1979; supplement 1980-1984.

* **WHO (1979)** Traditional birth attendants, an annotated bibliography on their training, utilisation and evaluation. HMD/NUR/99.1. Also Supplement I (1981) HMD/NUR/81.1 and

Notes

Notes

Addenda

► This symbol, which can be found at relevant points in the bibliography sections 1-11, is to indicate the position of an addendum.

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- 2.2.4.5. Care of the malnourished child
- p. 125 US Dept. Health and Human Services (1969) Malnutrition and learning. Adapted from American Education, December 1969.
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- 4.2.1. Healthy Mothers
- p. 154 WHO (1984) Health and family planning. In Point of Fact 23. Eng. Fr.
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4.4.2.7. Intrauterine devices

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ISBN: 0-9507503-3-6